Rocky Mountain Medical Journal

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In This Issue

Vol. 48—No. 4
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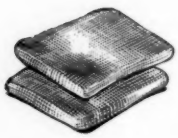

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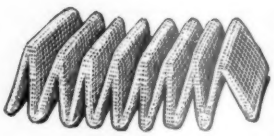

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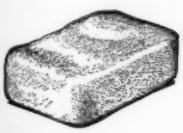

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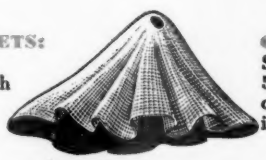

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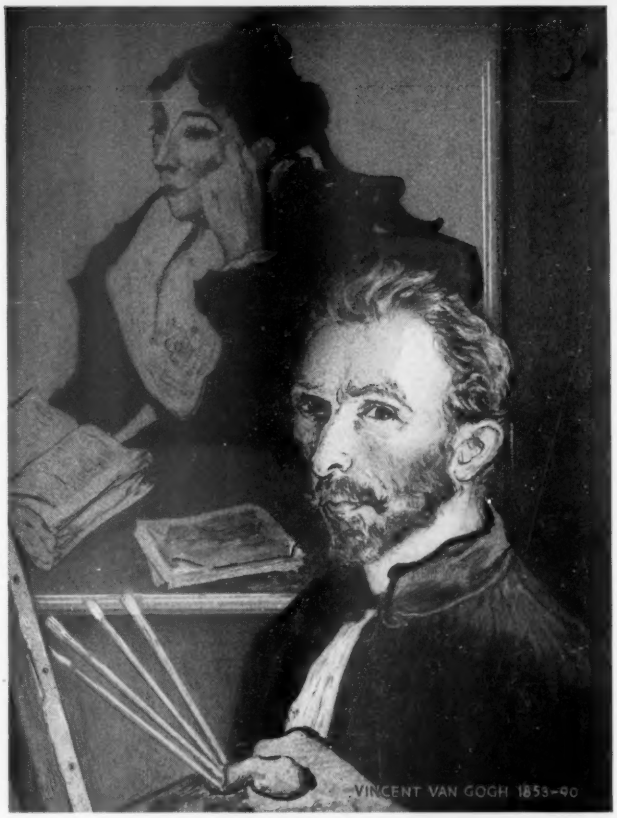

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Manuscripts: Scientific Articles, Case Reports, etc., from any state for which this is the Official Journal should be submitted to the Scientific Editor for that state as named in the Editorial Board, above. Other material from any participating state should be submitted to the Associate Editor for that state as named above. Manuscripts from outside the Rocky Mountain area should be sent direct to the Journal office. Manuscripts must be typewritten, double or triple spaced, using only one side of each sheet. It is the policy of this Journal to omit bibliographies.

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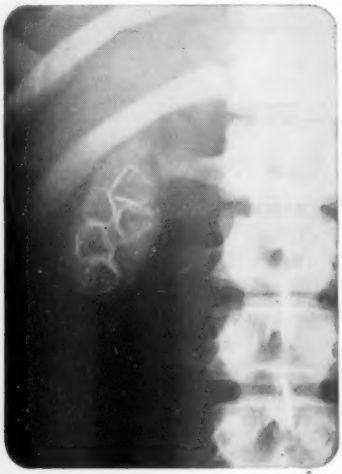

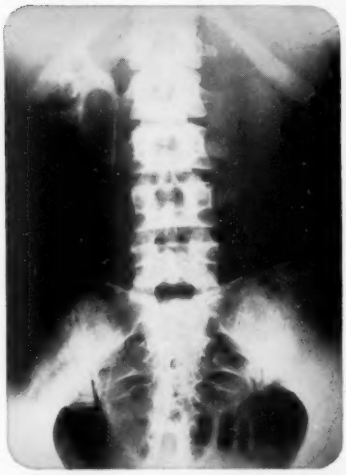

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THE COLORADO STATE MEDICAL SOCIETY

NEXT ANNUAL SESSION: SHIRLEY-SAVOY HOTEL, DENVER, SEPTEMBER 18, 19, 20, 21, 1951.

OFFICERS

Terms of Officers and Committees expire at the Annual Session in the year indicated. Where no year is indicated, the term is for one year only and expires at the 1951 Annual Session.

President: Ervin A. Hinds, Denver.
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Vice President: Samuel P. Newman, Denver.
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(The above nine officers compose the Board of Trustees of which Dr. Samuel P. Newman is the 1950-1951 Chairman.)

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Foundation Advocate: Walter W. King, Denver.

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General Counsel: Mr. J. Peter Nordlund, Attorney-at-Law. Denver.

STANDING COMMITTEES

Arrangements: Wm. M. Covode, Denver, Chairman; others to be appointed.

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Sub-Committee on Monthly Health Article: R. C. Scannell, Denver, Chairman; F. A. Humphrey, Fort Collins; H. J. Dodge, Denver; C. F. Kemper, Denver; Edgar Durbin, Denver; Mariana Gardner, Denver.

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Chronic Diseases: Robert W. Gordon, Denver, Chairman; Robert W. Vines, Denver; C. F. Kemper, Denver; Ward Darley, Denver; George C. Christie, Canon City; Thomas Stjernholm, Pueblo; George A. Unfug, Pueblo; Vincent G. Cedarblade, Denver; Abe Ravin, Denver; Lawrence L. Hick, Delta; Theodore E. Heins, Greeley; Richard F. LaForce, Sterling; James W. Lewis, Colorado Springs; James D. Stewart, Fort Collins.

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THE COLORADO STATE MEDICAL SOCIETY

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Representatives to Adult Education Council: Cyrus W. Anderson and William E. Hay, both of Denver.

Rocky Mountain Medical Conference: G. P. Lingenfelter, Denver, Chairman, 1953; D. W. Macomber, Denver, 1954; L. Clark Hepp, Denver, 1953; Ward Darley, Denver, 1951; Terry J. Gromer, Denver, 1955.

MONTANA MEDICAL ASSOCIATION

NEXT ANNUAL SESSION: GREAT FALLS, SEPTEMBER 13, 14, 15, 16, 1951.

OFFICERS, 1950-1951

Terms of Officers and Committees expire at the Annual Session in the year indicated. Where no year is indicated, the term is for one year only and expires at 1951 Annual Session.

President: Clyde H. Frederickson, Missoula.
President Elect: Frank L. McPhail, Great Falls.
Vice President: James M. Flinn, Helena.
Secretary-Treasurer (in absentia): H. T. Caraway, Billings.
Asst. and Acting Secretary-Treasurer: Everett H. Lindstrom, Helena.
Executive Secretary: Mr. L. R. Hegland, 240 Stapleton Building, Billings, Montana.
Delegate to American Medical Association: Raymond F. Peterson, Butte; Alternate, Thomas L. Hawkins, Helena.

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Industrial Welfare Committee: R. B. Richardson, Chairman, Great Falls; Donald A. Atkins, Butte; Richard E. Brogan, Billings; Paul J. Seifert, Libby; Frank L. Unmack, Deer Lodge.

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Public Health Committee: Frank L. McPhail, Chairman, Great Falls; Louis W. Allard, Billings; M. O. Burns, Kalispell; William F. Cashmore, Helena; B. C. Farrand, Jordan; Harry V. Gibson, Great Falls; Walter H. Hagen, Billings; E. L. Hall, Great Falls; Thomas L. Hawkins, Helena; Eugene Hildebrand, Great Falls; Amos R. Little, Helena; R. B. Richardson, Great Falls; Ferdinand R. Schemm, Great Falls; Philip A. Smith, Glasgow; Albert L. Vadheim, Jr., Bozeman; Winfield S. Wilder, Great Falls.

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Hospital Relations Committee: Eugene Hildebrand, Chairman, Great Falls; Robert B. Beans, Great Falls; Walter B. Cox, Missoula; Edward W. Gibbs, Billings; Robert S. Leighton, Great Falls; William W. McLaughlin, Great Falls; Mary E. Martin, Billings; Raymond F. Peterson, Butte; Grant P. Raitt, Billings.

Mental Hygiene Committee: Winfield S. Wilder, Chairman, Great Falls; James J. Bulger, Great Falls; Roger W. Clapp, Butte; J. E. Kress, Missoula; Martin A. Ruona, Billings; Maurice A. Shillington, Glendive.


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EVAPORATED
FORMULA FOR INFANTS
MEAD'S
DALACTUM
EVAPORATED
FORMULA FOR INFANTS
MEAD'S
RG

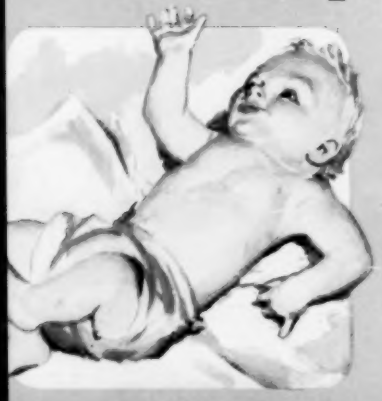
Time-tested formulas *approved by physician*

For four decades, the use of cow's milk, water and Dextri-Maltose® formulas has enjoyed wide pediatric acceptance. And successful clinical results attest the soundness of these formulas.

A time-saving form *appreciated by mothers*

Lactum and Dalactum are prepared for use simply by adding water.

For optimum nutrition of infants



Lactum is an evaporated whole milk and Dextri-Maltose formula designed for full term infants.

Dalactum is a low fat form designed for premature a full term infants with poor tolerance.

Both Lactum and Dalactum are generous in protein, for optimum growth and development.

MEAD'S

MEAD JOHNSON & CO.
EVANSVILLE 21, IND., U. S. A.

NEW MEXICO MEDICAL SOCIETY

NEXT ANNUAL SESSION: LA FONDA HOTEL, SANTA FE, MAY 3, 4, 5, 1951

OFFICERS—1950-51

President: I. J. Marshall, Roswell.
President-Elect: Leland S. Evans, Las Cruces.
Vice President: Coy S. Stone, Hobbs.
Secretary-Treasurer: Lucien G. Rice, Jr., Albuquerque.
Executive Secretary: Mr. Ralph R. Marshall, Albuquerque.

Councilors (2 years): Carl Mulky, Albuquerque; J. C. Sedgwick, Las Cruces. **(2 years):** W. D. Dabbs, Clovis; A. C. Shuler, Carlsbad. **(1 year):** A. S. Lathrop, Santa Fe; C. H. Gellenthien, Valmora. **(3 years).**
Delegate to A.M.A.: John F. Conway, Clovis, 1951.
Alternate Delegate to A.M.A.: C. H. Gellenthien, Valmora, 1951.

COMMITTEES—1950-1951

Basic Science Board: V. E. Berchtold, M.D., Santa Fe, Chairman; W. E. Nissen, M.D., Albuquerque; Walter A. Stark, M.D., Las Vegas.

Board of Supervisors: Two Years: C. Pardue Bunch, M.D., Artesia, Chairman; H. L. January, M.D., Albuquerque, Secretary; V. E. Berchtold, M.D., Santa Fe; John F. Conway, M.D., Clovis. One Year: W. E. Badger, M.D., Hobbs; L. J. Whitaker, M.D., Deming; H. M. Mortimer, M.D., Las Vegas; Frank W. Parker, M.D., Gallup.

Cancer: Murray M. Friedman, M.D., Santa Fe, Chairman; W. N. Worthington, M.D., Roswell; J. R. Van Atta, M.D., Albuquerque; J. W. Greesman, M.D., Albuquerque; C. L. Womack, M.D., Carlsbad.

Diabetic: Benjamin Barzune, M.D., Eunice, Chairman; John C. Mitchell, M.D., Silver City; Roy B. Robertson, M.D., Albuquerque.

Advisory Committee on Insurance Compensation: L. M. Overton, M.D., Albuquerque, Chairman; R. E. Forbis, M.D., Albuquerque; Edward Parnall, M.D., Albuquerque.

Indigent-Medical Care Committee: W. O. Connor, M.D., Albuquerque, Chairman; I. L. Neavy, M.D., Santa Fe; James L. McCrory, M.D., Santa Fe.

National Emergency Medical Service: Anthony E. Reyment, M.D., Santa Fe, Chairman; Loren F. Blaney, M.D., Los Alamos; Harry O. Whipple, M.D., Los Alamos; Albert Maisel, M.D., Albuquerque; C. H. Douthirt, M.D., Santa Fe.

Legislative and Public Policy: A. S. Lathrop, M.D., Santa Fe, Chairman; J. W. Hannett, M.D., Albuquerque; C. B. Elliott, M.D., Raton; John F. Cotnam, M.D., Clovis; J. A. Evans, M.D., Las Vegas; G. S. Morrison, M.D., Roswell; R. A. Watts, M.D., Silver City; Ashley Pond, M.D., Taos; C. F. Kettel, M.D., Gallup; W. L. Minear, M.D., Hot Springs; Leland S. Evans, M.D., Las Cruces; W. M. Thaxton, M.D., Tucumcari; Robert E. Carter, M.D., Los Alamos; W. O. Connor, Jr., M.D., Albuquerque; Coy S Stone, M.D., Hobbs; A. C. Shuler, M.D., Carlsbad; W. J. Hossley, M.D., Deming.

Public Relations: Earl L. Malone, M.D., Roswell, Chairman; H. W. Gillett, M.D., Lovington; C. M. Thompson, M.D., Albuquerque; E. P. Hanner, M.D., Santa Fe; C. P. Bunch, M.D., Artesia.

Rural Medical Service: Stuart W. Adler, M.D., Albuquerque, Chairman; D. T. Wier, M.D., Belen; Robert J. Saul, M.D., Mountainair; James W. Wiggins, M.D., Albuquerque; J. P. Turner, M.D., Carrizozo.

Infancy and Maternal Care: S. M. Gonzales, M.D., Santa Fe, Chairman; A. R. Clauser, M.D., Albuquerque; D. C. Badger, M.D., Hobbs; George W. Prothro, M.D., Clovis; Marion Hotopp, M.D., Santa Fe; M. K. Wylder, M.D., Albuquerque.

Venereal Disease Control: Sam J. Jelso, M.D., Albuquerque, Chairman; C. H. Douthirt, M.D., Santa Fe; L. M. Miles, M.D., Albuquerque; Vincent Accardi, M.D., Gallup; F. C. Bohannon, M.D., Carlsbad.

Tuberculosis: Carl H. Gellenthien, M.D., Valmora, Chairman; William H. Thearle, M.D., Albuquerque; Carl Mulky, M.D., Albuquerque; H. C. Jernigan, M.D., Albuquerque; H. S. A. Alexander, M.D., Santa Fe.

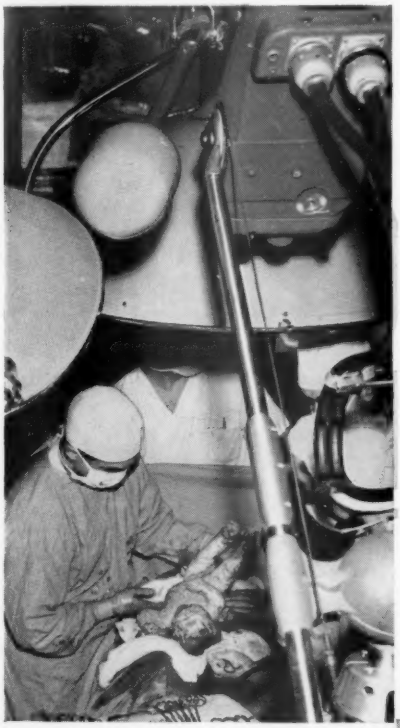
Woman's Auxiliary Advisory: Carl Mulky, M.D., Albuquerque, Chairman; Philip Travers, M.D., Santa Fe; Roy B. Robertson, M.D., Albuquerque.

Rocky Mountain Medical Conference: Carl H. Gellenthien, M.D., Valmora, Chairman; Carl Mulky, M.D., Albuquerque; V. K. Adams, M.D., Raton; T. B. Hoover, M.D., Tucumcari; W. A. Stark, M.D., Las Vegas.

The Rocky Mountain Medical Conference

is pleased to announce a three day program of medicine and surgery on

Color Television



May 9, 10, and 11, in Denver
The Rocky Mountain Medical Conference
will present, through Medicine's great
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a comprehensive program of late
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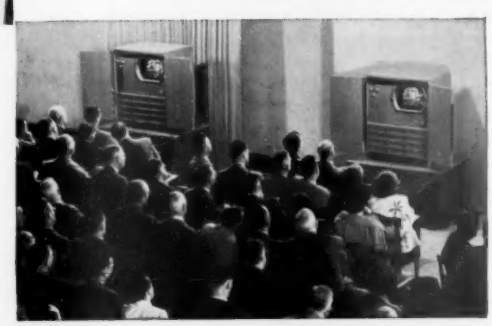

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as a contribution to medical education

THE UTAH STATE MEDICAL ASSOCIATION

NEXT ANNUAL SESSION, SALT LAKE CITY, SEPTEMBER 13, 14, 15, 1951.

OFFICERS, 1950-1951

President: V. P. White, Salt Lake City.
President-Elect: L. W. Oaks, Provo.
Past President: Conrad H. Jensen, Ogden.
Honorary President: F. H. Raley, Salt Lake City.
First Vice President: K. B. Castleton, Salt Lake City.
Second Vice President: C. C. Randall, Logan.
Third Vice President: H. C. Stranquist, Ogden.
Secretary: T. C. Weggeland, Salt Lake City.
Executive Secretary: Mr. W. H. Tibbals, Salt Lake City.
Treasurer: L. J. Paul, Salt Lake City.
Councilor, First District: R. O. Porter, Logan.
Councilor, Second District: Vincent L. Rees, Salt Lake City.
Councilor, Third District: J. Russell Smith, Provo.
Delegate to A.M.A., 1950 and 1951: George M. Fister, Ogden.
Alternate Delegate to A.M.A., 1950 and 1951: J. J. Weight, Provo.

Editor of the Utah Section of the Rocky Mountain Medical Journal: R. P. Middleton, Salt Lake City.

Board of Supervisors: 1951, Ezra Cragun, Logan; 1952, Paul K. Edmunds, Cedar City; 1953, Earl L. Skidmore, Salt Lake City; 1954, J. C. Hubbard, Price; 1955, J. G. Olson, Ogden.

STANDING COMMITTEES

Rocky Mountain Medical Conference Continuing Committee: 1951, Clark Rich, Chairman, Ogden; 1952, Noall Z. Tanner, Layton; 1953, T. R. Seager, Vernal; 1954, R. P. Middleton, Salt Lake City; 1955, U. R. Bryner, Salt Lake City.

Scientific Program Committee: T. C. Weggeland, Chairman, Salt Lake City; Vincent L. Rees, Salt Lake City; Fuller Bailey, Salt Lake City; Rowland H. Merrill, Salt Lake City; Paul Rasmussen, Salt Lake City.

Public Policy and Legislation Committee: 1951, F. R. King, Price; 1951, R. V. Larson, Roosevelt; 1951, W. B. West, Ogden; 1952, Chas. Ruggeri, Salt Lake City; 1952, J. C. Hubbard, Price; 1952, Wilford G. Biesinger, Springville; 1953, N. F. Hicken, Chairman, Salt Lake City; 1953, L. V. Broadbent, Cedar City; 1953, George Gasser, Logan.

Medical Defense Committee: 1951, R. W. Owens, Chairman, Salt Lake City; 1951, James Westwood, Provo; 1951, L. H. Merrill, Hiawatha; 1952, E. L. Hanson, Logan; 1952, Reed Farnsworth, Cedar City; 1952, H. A. Dewey, Richfield; 1953, John B. Cluff, Richfield; 1953, Paul A. Pemberton, Salt Lake City; 1953, Wendell Thomson, Ogden.

Medical Education and Hospitals Committee: 1951, John Bowen, Provo; 1951, George H. Curtis, Salt Lake City; 1951, G. S. Francis, Logan; 1952, Ralph Ellis, Ogden; 1952, Philip Price, Salt Lake City; 1952, W. H. Anderson, Ogden; 1953, T. C. Bauerlein, Chairman, Salt Lake City; 1953, E. R. Crowder, Salt Lake City; 1953, Galen O. Belden, Salt Lake City.

Medical Economics Committee: 1951, W. R. Merrill, Brigham City; 1951, A. W. Middleton, Chairman, Salt Lake City; 1952, Grant F. Kearns, Ogden; 1952, Preston Hughes, Spanish Fork; 1953, Hugh O. Brown, Salt Lake City.

Public Health Committee: 1951, R. N. Hirst, Ogden; 1952, Seth E. Smoot, Provo; 1952, James Z. Davis, Salt Lake City; 1953, K. B. Castleton, Chairman, Salt Lake City.

Tuberculosis and Cardiovascular Diseases Committee: E. M. Kilpatrick, Chairman, Salt Lake City; Preston Cutler, Salt Lake City; Fred W. Clausen, Salt Lake City; Drew M. Peterson, Ogden; J. H. Rupper, Provo; D. O. N. Lindberg, Ogden.

Cancer Committee: James P. Kerby, Chairman, Salt Lake City; Ray T. Woolsey, Salt Lake City; J. Elmer Nielsen, Salt Lake City; Erwin D. Zeman, Ogden; Riley G. Clark, Provo; W. J. Reichman, St. George; A. K. Hansen, Lewiston; R. V. Larsen, Roosevelt; R. N. Malouf, Richfield; Quinn A. Whiting, Price.

Fracture Committee: A. M. Okelberry, Chairman, Salt Lake City; Reed S. Clegg, Salt Lake City; Louis S. Perry, Ogden; Norman R. Beck, Salt Lake City.

Necrology Committee: L. A. Stevenson, Chairman, Salt Lake City; Alan S. Crandall, Salt Lake City.

Industrial Health Committee: F. J. Winget, Chairman, Salt Lake City; Benjamin F. Robison, Salt Lake City; L. Wayne Allred, Provo; Noall Tanner, Layton; Chester B. Powell, Salt Lake City.

Advisory Committee to the Woman's Auxiliary: N. F. Hicken, Chairman, Salt Lake City; V. H. Johnson, Ogden; Roy B. Hammond, Provo.

Public Relations Committee: T. E. Robinson, Chairman, Salt Lake City; J. A. Gubler, Salt Lake City; Donald M. Moore, Ogden; R. W. Farnsworth, Cedar City; Harry J. Brown, Provo; George B. Jadsen, Mt. Pleasant; Ray E. Spendlove, Vernal; J. Paul Burgess, Hyrum.

Mental Health Committee: O. P. Heninger, Provo; Wm. D. O'Gorman, Ogden; Louis G. Moench, Salt Lake City; Roy A. Darke, Chairman, Salt Lake City.

Rural Health Committee: J. E. Trowbridge, Chairman, Bountiful; T. R. Seager, Vernal; T. M. Aldous, Tooele; E. G. Wright, Midvale; Byron N. Benson, Garland.

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Procurement and Assignment Committee: Frank K. Bartlett, Ogden; John J. Galligan, Salt Lake City; John H. Clark, Salt Lake City; C. Eliot Snow, Salt Lake City; J. Russell Smith, Provo.

Civilian Defense Committee: L. J. Paul, Chairman, Salt Lake City; Leo W. Benson, Ogden; Riley G. Clark, Provo.

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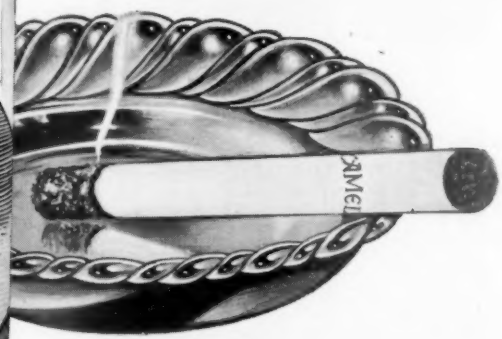

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That's T for Throat, T for Taste. See if the 30-day Camel Mildness Test doesn't give you the most enjoyment you've ever had from smoking.

MORE PEOPLE SMOKE CAMELS

than any other cigarette!

THE WYOMING STATE MEDICAL SOCIETY

NEXT ANNUAL SESSION: ROCK SPRINGS, SEPTEMBER 27, 28, 29, 1951

OFFICERS

President: Karl E. Krueger, Rock Springs.

President-Elect: Paul R. Holtz, Lander.

Vice President: E. J. Guilfoyle, Newcastle.

Secretary: G. W. Koford, Cheyenne.

Treasurer: Peter M. Schunk, Sheridan.

Executive Secretary: Mr. Arthur R. Abbey, Cheyenne.

Delegate to A.M.A.: Roscoe H. Reeve, Casper.

Alternate Delegate to A.M.A.: B. J. Sullivan, Laramie.

COMMITTEES

Rocky Mountain Medical Conference: Earl Whedon, Chairman, Sheridan; George H. Phelps, Cheyenne; H. L. Harvey, Casper; C. W. Jeffrey, Rawlins; L. W. Storey, Laramie.

Syphilis Committee: L. H. Wilmoth, Chairman, Lander; F. H. Haigler, Casper; N. E. Morad, Casper; C. L. Rogers, Sheridan; Benjamin Gitlitz, Thermopolis.

Cancer Committee: John Gramlich, Chairman, Cheyenne; M. C. Henrich, Casper; Thomas B. Croft, Lovell; J. R. Newnam, Cheyenne; Franklin Yoder, Cheyenne.

Medical Economics Committee: C. L. Rogers, Chairman, Sheridan; Nels A. Vicklund, Thermopolis; H. L. Harvey, Casper; J. S. Hellewell, Evanston; H. E. Stuckenhoff, Casper.

Fracture Committee and Industrial Health: Gordon Whiston, Chairman, Casper; W. K. Mylar, Cheyenne; DeWitt Dominick, Cody; E. C. Pelton, Laramie; Lowell D. Kattenhorn, Powell; J. E. Hoadley, Gillette; Philip Teal, Cheyenne.

Advisory Committee to Selective Service on Procurement and Assignment of Physicians: Sam S. Zuckerman, Chairman, Cheyenne; Roscoe H. Reeve, Casper; E. W. DeKay, Laramie.

Elected: Medical Defense Committee: DeWitt Dominick, Chairman, Cody; W. A. Bunten, Cheyenne; E. W. DeKay, Laramie.

Councillors: E. W. DeKay, Chairman, Laramie; Earl Whedon, Sheridan; George Baker, Casper; DeWitt Dominick, Cody; George H. Phelps, Cheyenne; Kral Krueger, President, Rock Springs; Glenn W. Koford, Secretary, Cheyenne.

Advisory to Woman's Auxiliary: Thomas B. Croft, Chairman, Lovell; John R. Bunch, Laramie; W. A. Bunten, Cheyenne; J. Cedric Jones, Cody.

Veterans Affairs and Military Service Committee: G. W. Koford, Chairman, Cheyenne; Jack Rowlett, Laramie; L. R. Morgan, Torrington; R. C. Stratton, Green River; Bernard Sullivan, Laramie; James Sampson, Sheridan; G. M. Knapp, Casper; A. J. Allegretti, Cheyenne; DeWitt Dominick, Cody; E. J. Guilfoyle, Newcastle; George H. Phelps, Cheyenne.

Blue Cross Hospital Committee: Russell Williams, Chairman, 1954, Cheyenne; E. W. DeKay, 1951, Laramie; J. Cedric Jones, 1952, Cody; J. W. Sampson, 1953, Sheridan.

Public Policy and Legislation: George H. Phelps, Chairman, Cheyenne; George Baker, Casper; W. A. Bunten, Cheyenne; E. W. DeKay, Laramie; L. H. Wilmoth, Lander; G. W. Koford, Cheyenne; Paul Holtz, Lander; R. H. Reeve, Casper.

Poliomyelitis Committee: L. Cohen, Chairman, Cheyenne; E. W. Gardner, Douglas; E. C. Ridgway, Cody; Franklin Yoder, Cheyenne; Bernard Stack, Thermopolis; Philip Teal, Cheyenne; G. O. Beach, Casper; B. J. Sullivan, Laramie.

State Institutions Advisory: R. H. Kanable, Chairman, Basin; George H. Phelps, Cheyenne; Franklin Yoder, Cheyenne; George R. James, Casper; C. D. Anton, Sheridan; J. S. Hellewell, Evanston.

Necrology Committee: Earl Whedon, Chairman, Sheridan; D. G. MacLeod, Jackson; Franklin Yoder, Cheyenne.

Public Health Department—Liaison Committee: E. C. Ridgway, Chairman, Cody; R. P. Fitzgerald, Casper; J. W. Sampson, Sheridan; R. C. Stratton, Green River; O. K. Scott, Casper; E. G. Johnson, Douglas.

Rural Health Committee: Paul Holtz, Chairman, Lander; William K. Rosene, Wheatland; Andrew Bunten, Cheyenne; G. M. Knapp, Casper; R. N. Bridenbaugh, Powell.

Child Health Committee: O. K. Scott, Chairman, Casper; Paul Emerson, Cheyenne; L. Cohen, Cheyenne; J. T. Murphy, Casper; E. C. Ridgway, Cody; David M. Flett, Cheyenne; Arthur R. Abbey, Cheyenne.

Council on National Emergency Medical Service: George H. Phelps, Chairman, Cheyenne; R. H. Reeve, Casper; E. W. DeKay, Laramie; P. M. Schunk, Sheridan; Paul R. Holtz, Lander; Albert T. Sudman, Green River.

Judicial and Advisory Committee: District No. 1, J. D. Shingle, Chairman, Cheyenne; District No. 7, George Baker, Casper; District No. 1, George H. Phelps, Cheyenne; District No. 1, R. I. Williams, Cheyenne; District No. 2, C. W. Jeffrey, Rawlins; District No. 3, J. S. Hellewell, Evanston; District No. 4, P. M. Schunk, Sheridan; District No. 5, J. Cedric Jones, Cody; District No. 6, E. J. Guilfoyle, Newcastle.

COLORADO HOSPITAL ASSOCIATION

OFFICERS

President: Louis Liswood, National Jewish Hospital, Denver.

President-Elect: Henry H. Hill, Weld County Hospital, Greeley.

Vice President: Sr. M. Lina, St. Francis Hospital, Colorado Springs.

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Executive Secretary: R. A. Pontow, Colorado General Hospital, Denver.

Trustees: DeMoss Taliaferro, Children's Hospital, Denver (1950); Roy R. Anderson, Presbyterian Hospital, Denver (1950); Rev. Allen H. Erb, Mennonite Hospital and Sanitarium, La Junta (1951); Roy R. Prangley, St. Luke's Hospital, Denver (1952); Hubert W. Hughes, General-Rose Memorial Hospital, Denver (1952).

Delegate to American Hospital Association: Msgr. John R. Mulroy, Catholic Hospitals, Denver.

Alternate: Herbert A. Black, M.D., Parkview Hospital, Pueblo.

STANDING COMMITTEES

President—Ex-Officio Member.

Secretary—Ex-Officio Member.

Auditing: R. K. Mortensen, Chairman, St. Luke's Hospital, Denver; Ed Smith, Boulder Colorado Sanitarium & Hospital, Boulder; Otto F. Keller, D. & R. G. W. Hospital, Salida.

Constitution and Rules: James P. Dixon, M.D., Chairman, Denver General Hospital, Denver; Samuel S. Golden, M.D., Beth Israel Hospital, Denver; Sister Mary Lina, St. Francis Hospital, Colorado Springs.

Legislative: Hubert Hughes, Chairman, General Rose Memorial Hospital, Denver; Msgr. John R. Mulroy, Catholic Hospitals, Denver; DeMoss Taliaferro, Children's Hospital, Denver; Roy Anderson, Presbyterian Hospital, Denver; H. F. Zimoski, Jr., Memorial Hospital, Colorado Springs; F. H. Zimmerman, M.D., Colorado State Hospital, Pueblo.

Membership: G. A. W. Currie, M.D., Chairman, Colorado General Hospital, Denver; A. Tergerson, Longmont Hospital and Clinic, Inc., Longmont; Sister M. Ascella, St. Joseph's Hospital, Denver.

Resolutions: John Peterson, Larimer County Hospital, Fort Collins; Sister M. Raymond, Mercy Hospital, Denver.

Nominating: Msgr. John R. Mulroy, Chairman, Catholic Hospitals, Denver; G. A. W. Currie, M.D., Colorado General Hospital, Denver; Roy Anderson, Presbyterian Hospital, Denver.

Program: Owen B. Stubben, Chairman, Denver General Hospital, Denver; Henry H. Hill, Weld County Hospital, Greeley; Esther Thornton, R.N., Washington County Public Hospital, Akron.

Nursing Education: Roy Prangley, Chairman, St. Luke's Hospital, Denver; Sister M. Hugolina, St. Anthony's Hospital, Denver; Margaret E. Paetznick, Denver General Hospital, Denver; Richard Conner, Mercy Hospital, Denver; Mrs. Henrietta Loughran, University of Colorado School of Nursing, Denver.

Public Education: Charles K. LeVine, Chairman, J.C.R.S., Spivak; Ward Darley, M.D., University of Colorado Department of Medicine, Denver; A. Tergersen, Longmont Hospital and Clinic, Inc., Longmont; James P. Dixon, M.D., Denver General Hospital, Denver.

SPECIAL COMMITTEE

Public Relations: James P. Dixon, M.D., Chairman, Denver General Hospital, Denver; Sister Mary Lina, St. Francis Hospital, Colorado Springs.

Rates and Charges: Roy Anderson, Chairman, Presbyterian Hospital, Denver; Msgr. John R. Mulroy, Catholic Hospitals, Denver; Roy Prangley, St. Luke's Hospital, Denver; Richard Conner, Mercy Hospital, Denver; Rev. Allen H. Erb, Mennonite Hospital and Sanitarium, La Junta; DeMoss Taliaferro, Children's Hospital, Denver.

State Board of Health Advisory: Msgr. John R. Mulroy, Chairman, Catholic Hospitals, Denver; DeMoss Taliaferro, Children's Hospital, Denver; Herbert A. Black, M.D., Parkview Hospital, Pueblo.

Committee on Hospital Licensing Regulations and Standards: Msgr. John R. Mulroy, Chairman, Catholic Hospitals, Denver; Roy R. Prangley, St. Luke's Hospital, Denver; Owen B. Stubben, Denver General Hospital, Denver; DeMoss Taliaferro, Children's Hospital, Denver; Roy Anderson, Presbyterian Hospital, Denver.

Premature Infant Care: DeMoss Taliaferro, Chairman, Children's Hospital, Denver; Roy Anderson, Presbyterian Hospital, Denver.

Rehabilitation Center: James P. Dixon, M.D., Denver General Hospital, Denver; Msgr. John R. Mulroy, Catholic Hospitals, Denver; Louis M. Liswood, National Jewish Hospital, Denver.

Inter-Professional Council: Hubert W. Hughes, St. Anthony Hospital, Denver.

NORM

Normal schedule of development (auxodrome) plotted on Wetzel Grid.[1]

CURVE A

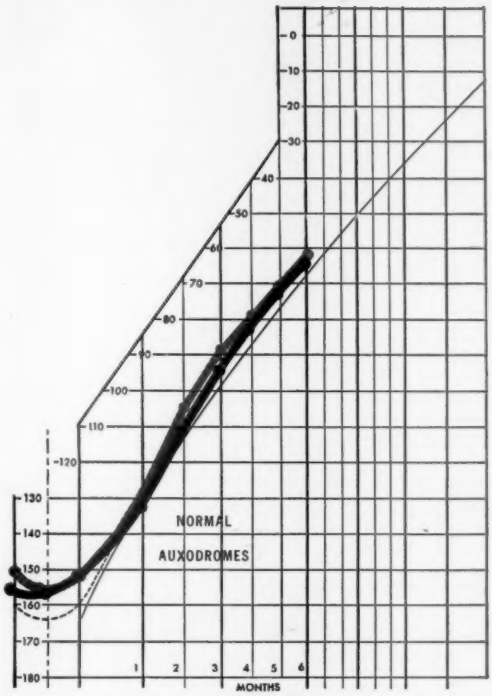
Composite Wetzel Grid auxodrome of 60 unselected infants on S-M-A from birth to 6 months of age.

CURVE B

Growth data, recomputed on Wetzel Grid, based on "selected subjects, most of whom were favored by environment;"[2] age: from birth to 6 months.

1. Wetzel, N. C.: J. Pediat. *29*:439, 1946.

2. Jackson, R. L., and Kelly, H. G.: J. Pediat. *27*:215, 1945.



Comparative development rates prove...

S-M-A®

builds husky babies

Recent clinical studies of development rates of *unselected* S-M-A-fed babies (curve A on chart) prove its value. The growth results compare favorably with "standards which are considered to approach the optimum for general pediatric practice."[2] (curve B on chart).

Because it is patterned after human milk **S-M-A®**

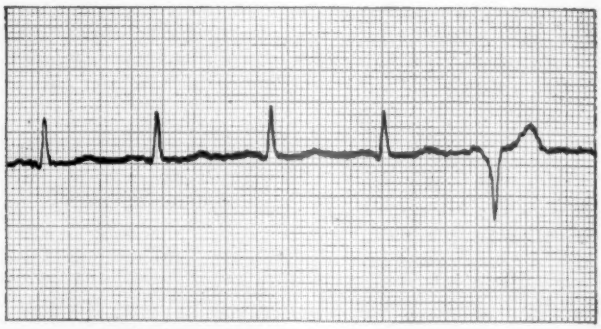
with Vitamin C added
is recognized as an outstanding food for babies.

Wyeth Incorporated, Philadelphia 2, Pa.

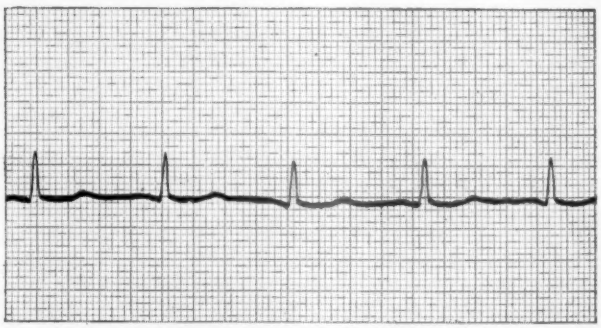
Wyeth®

a significant advance in the treatment of ventricular arrhythmias . . . .

Oral PRONESTYL
in ventricular premature contractions



Lead I. Control tracing, ventricular premature contraction.



Lead I. Tracing one week later; patient maintained on 2 Gm. Pronestyl per day. Normal sinus rhythm.

....PRONESTYL *Hydrochloride*

less toxic than quinidine

Indications and Dosage

IN CONSCIOUS PATIENTS

For the treatment of ventricular tachycardia:

Orally: 1 Gm. (4 capsules) followed by 0.5-1.0 Gm. (2 to 4 capsules) every four to six hours as indicated.

Intravenously: 200-1000 mg. (2 to 10 cc.). *Caution*—administer no more than 200 mg. (2 cc.) per minute.

Hypotension may occur during intravenous use in conscious patients. As a precautionary measure, administer at a rate no greater than 200 mg. (2 cc.) per minute to a total of no more than 1 Gm. Electrocardiographic tracings should be made during injection so that injection may be discontinued when tachycardia is interrupted. Blood pressure recordings should be made frequently during injection. *If marked hypotension occurs, rate of injection should be slowed or stopped.*

For the treatment of runs of ventricular extrasystoles:

Orally: 0.5 Gm. (2 capsules) every four to six hours as indicated.

IN ANESTHESIA

During anesthesia, to correct ventricular arrhythmias:

Intravenously: 100-500 mg. (1 to 5 cc.). *Caution*—administer no more than 200 mg. (2 cc.) per minute.

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Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.
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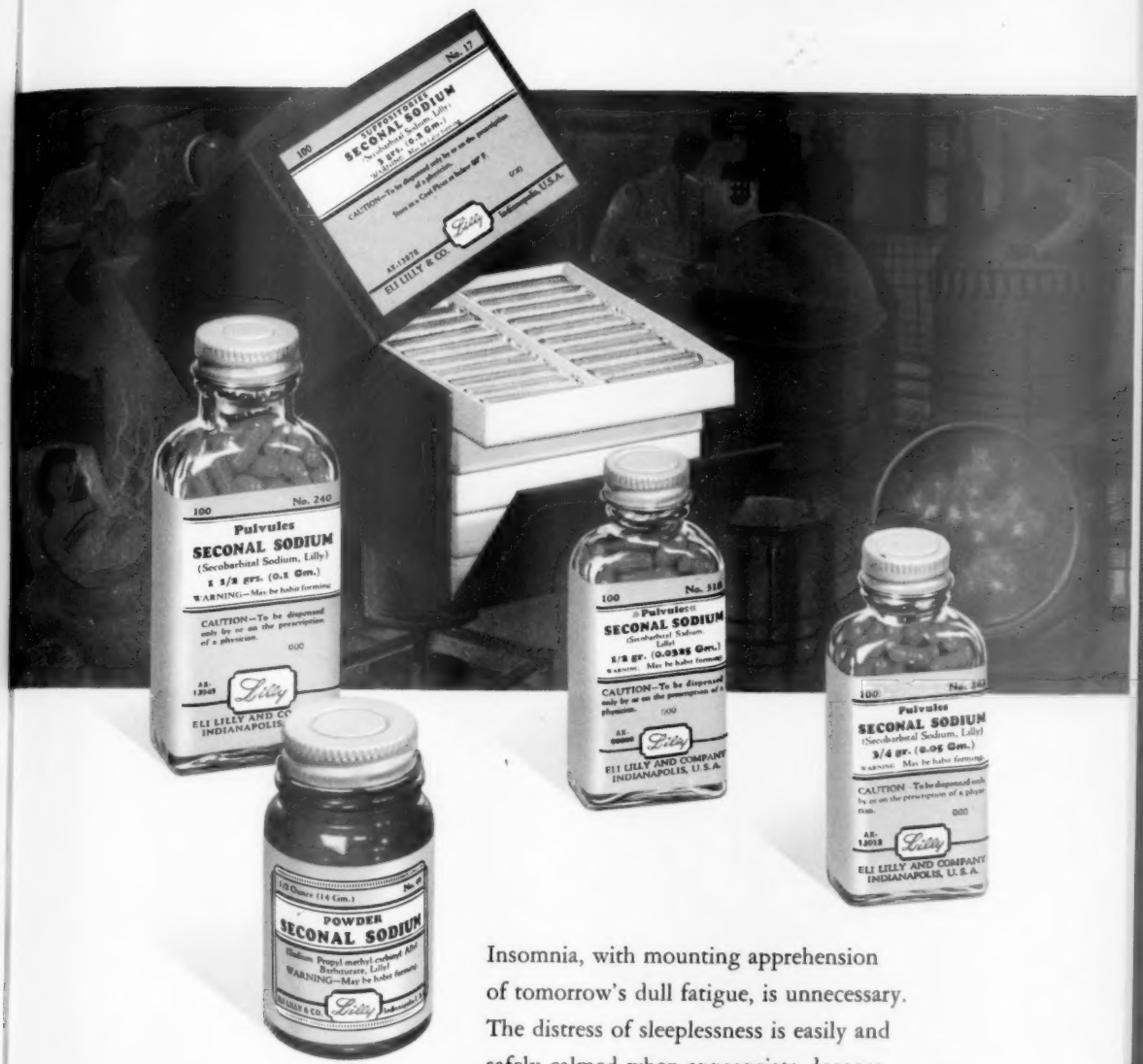
Great gift of sleep



Insomnia, with mounting apprehension of tomorrow's dull fatigue, is unnecessary. The distress of sleeplessness is easily and safely calmed when appropriate dosages of 'Seconal Sodium' (Secobarbital Sodium, *Lilly*) are prescribed. Refreshing sleep quickly follows.

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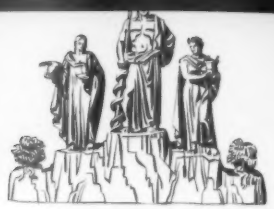
Lilly

SINCE 1876



LILLY SINCE 1876

Improvement

Crude as it now appears, the equipment which Colonel Eli Lilly devised for coating gelatin capsules seventy-five years ago was a decided improvement over earlier hand methods. Soon this machine which impaled pills on needle points was abandoned for a still better procedure which left the coatings intact. Again, another step forward was taken a few years later when Eli Lilly and Company started making the now well-known empty gelatin capsules. Better materials, faster machines, lower costs continue to result from current research in medicinal coatings at the Lilly Laboratories. This is just one more example of how American industry makes progress when it is encouraged by the rewards from improvement and is spurred by competition in a system of free enterprise.

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Rocky Mountain Medical Journal

APRIL 1951

Colorado
Montana
New Mexico
Utah
Wyoming

Editorial

Make Early Plans For May Meetings

MAY, 1951, will be the Meetin'st Month in Many a Moon! Remember, that is just a month away. It will be very wise, therefore, for each of us to plan in advance, so that the session closest to each individual heart will not be overlooked in the rush.

As most readers will have already noticed from the tinted pages in this issue, we feature the program of the Rocky Mountain Medical Conference—our own particular five-state endeavor. Our biennial Conference now returns to Denver to begin its second rotation among the Rocky Mountain states.

So, we can't help but feel that May 9, 10 and 11, the Rocky Mountain dates in Denver, are the most important dates to reserve for next month.

But that's not all—it is not even the beginning, chronologically. New Mexico's own Annual Session will be held in Santa Fe, May 3, 4 and 5. Those of us in New Mexico and Southern Colorado thus should plan on two principal meetings and two sets of important dates next month.

Then Utah's famed Ogden Surgical Society convenes its annual three-day session in Ogden May 23, 24 and 25. This Society changes its dates this year from the usual late April to late May, so Utahans and their friends in Southern Idaho, Southwestern Wyoming and many other parts of the region should bear this change in mind. Ogden always stages a fine meeting.

And, right in the middle of the month, the Aero-Medical Association conducts its national meeting in Denver, featuring a program of special interest to physicians concerned with the medical aspects of flight and high altitude. These dates are May 14, 15 and 16.

If these meetings should be insufficient, we might mention that other May gatherings are right nearby and handy—the Nebraska, Kansas and Oklahoma state societies also meet in May!

All the programs appear to be excellent. Look over those in this issue's Organization Section as well as the Rocky Mountain Conference pages—pick any one, any two or more, as your time and pocketbook will allow. We do suggest that you make your plans early. Attendance at all these meetings should be big enough to put some strain on accommodations in their respective cities.

Greetings!

IT IS WITH humble pride that the Wyoming Health Officer takes over the duty of being scientific editor of the Rocky Mountain Medical Journal for Wyoming. The Managing Editor was kind enough to suggest this means of introduction to the truly select group of readers covered by this publication.

You will have noted in last month's issue an editorial by Dr. Earl Whedon, retiring scientific editor for Wyoming. He was kind enough to suggest the selection of his successor to the State Medical Society Councillors.

Only the future will tell whether we will have adequately performed our duties. Your cooperation and counsel (and properly prepared manuscripts) will be gratefully accepted.

FRANKLIN D. YODER, M.D.

Where Do Mink Coats Come From, Alice?

WHEN we were young children we thought "Alice in Wonderland" was simply wonderful. During adolescence we passed it off as just another impossible fairy tale —rather laughable that even an eight-year-old would believe such stuff, y'know! Then as we grew old enough we recognized it as masterful writing by a keen psychologist, one of literature's great fantasies.

Alas! Now we are aware that the greatest fantasy of our time is not in that or in any other book, but in the real life Washington, D. C., headquarters of the Truman Mis-Deal.

Latest confirmation of this, if any is needed, is contained in an Associated Press dispatch which reveals that the Farmers Home Administration, an agency of the U. S. Department of Agriculture, has made loans totaling $2,660,000.00 to fur-farm operators within the last twenty-three months. (Yes, Alice, Mr. Brannan is from Denver; our Rocky Mountains should hide their heads in clouds of shame.)

Officials of the FHA said the loans averaged about $6,700.00, and said the largest loan was $300,000.00. They declined to name the borrowers, on the ground that the loans were confidential. The fact that the lenders, who are paid employees of us taxpayers, used our tax monies to assist "distressed" fur farmers seems to be of no moment. It is just another way of saying "the public be damned."

Let's remember that this Farmers Home Administration was formerly the Farm Security Administration, and that it was created and presumably still operates primarily for the purpose of extending low-interest-rate, long term loans to low-income farmers who cannot obtain bank credit. After a bumbling start under such master planners as Rexford Tugwell, the FSA settled down in the mid-1930s and for a while did a good job of rehabilitating small farmers who otherwise would have succumbed economically to the drouths and depression of those years. But it's a safe guess that even Mr. Tugwell would recoil from the principle of an agency set up to aid little fellows lending $300,000.00 to the operator of a fur farm—one of the most hazardous of all forms of speculation! Since World War II many inexperienced persons have entered so-called fur farming, and presumably the federal government is now engaged in the equally hazardous gamble of "bailing out" some of the failures, with our money, of course.

Can't we just imagine Alice saying to the Mad Hatter: "Sure, lend them the $300,000.00. It's only money from the taxpayers, and they have lots more."

And the Mad Hatter might reply: "And if this fur farmer is REAL lucky, who knows? He may produce the very mink that will qualify for another fur coat for another RFC stenographer."

Could be! It's even worth speculating that the last RFC fur coat came from a government-subsidized mink farm. That way, the money all stays in the family—or does it?

Actually, this is no fantasy. It is terribly, terribly serious. It is a tragic and un-American waste of everyone's hard-earned tax dollars in a period of international crisis and administration-encouraged inflation. This is the same federal administration to which too many medical school deans would like to turn for their future financing, the same people who want to socialize medicine, who have partially succeeded in socialized housing, and who, but for some Congressional investigating committees would still have the blanket of secrecy over the RFC scandals and would still laughingly call "red herrings" the charge that foreign spies had penetrated the highest departments of the United States government.

We feel like again thanking our Senators and Congressmen for those investigating committees. We feel like asking them to take a good look at the fur farming, too. You may want to do the same.

Original Articles

ACUTE APPENDICITIS*

PHILIP THOREK, M.D.
CHICAGO, ILLINOIS

The statement "only an appendix" is indeed a dangerous one. Since this condition still accounts for over 5,000 deaths per year in this country alone, a revival of interest and a renewal of methods of attack surely seem warranted. In studying acute appendicitis for the past fifteen years, both at Cook County Hospital and in private practice, certain specific ideas concerning the diagnosis and treatment have been formulated; these are presented herein.

In 1886, Reginald Heber Fitz of Harvard gave appendicitis its name. His description is considered one of the classics of medical literature. It is odd, however, that the condition was not discovered or described in the literature until such a late date. Anatomically the appendix was described in the sixteenth century; pathologically it was recognized in the eighteenth century; clinically it belongs to the nineteenth century; and therapeutically it is the challenge of the twentieth century.

Pathologic Physiology

In discussing inflammation and infection, the late Richard Jaffe stated: "There is no infection without stasis." Thus, if a gallbladder can empty itself there will be no cholecystitis, if a sinus drains itself there will be no sinusitis, and if an appendix evacuates itself there will be no appendicitis.

Micro-organisms always are present, but as long as they are kept in motion they cannot increase in number and do not gain a foothold in the tissues; thus no inflammatory response results. Fecaliths, kinks, bands, spasms, mucosal folds, or foreign bodies might act as the obstructing factor and permit the bacteria to multiply. How far this inflammatory response will progress cannot be foretold. It depends upon the completeness of the obstruction, the virulence of the micro-organism and the resistance of the host.

History and Symptoms

That certain types of people are predisposed to certain types of diseases cannot be denied. We know that the characteristic type for acute appendicitis is the young adult male. It is a disease which usually affects those in their teens and the second or third decades. There is no dogma in medicine, and although this disease may occur at any age, from the uterus to the grave, it becomes infrequent after the age of forty.

Any diffuse epigastric distress which localizes to the right lower quadrant within the first twenty-four to forty-eight hours is acute appendicitis until proved otherwise. Unfortunately, however, our patient does not use this terminology, but relates the same story in a different way. His terms for diffuse epigastric distress are "belly-ache," "spoiled stomach," "cramps," or "gas." His usual remark is "something I ate gave me a bellyache." He ofttimes heeds the advice of a well meaning friend who suggests a cathartic, and then some twenty-four hours later becomes concerned about a "sore spot" in the lower right side of his abdomen. It is at this time that he will usually consult the doctor.

The "Two Question Test" suggests the diagnosis in well over 70 per cent of cases of acute appendicitis (Fig. 1). Question number one: "Where was your pain when it started?" To this the patient usually points to his entire abdomen. Question number two: "Where does it hurt you now?" To this interrogation the patient usually points

*From the Departments of Surgery of the University of Illinois, Cook County Graduate School, American and Alexian Brothers' Hospitals.
Presented before the Tenth Annual Spring Clinic of Western Colorado, Grand Junction, Colorado, April 15, 1950.

to the region of McBurney's point. This is one of the simplest, most efficacious and rapid methods of diagnosing a case of acute appendicitis.

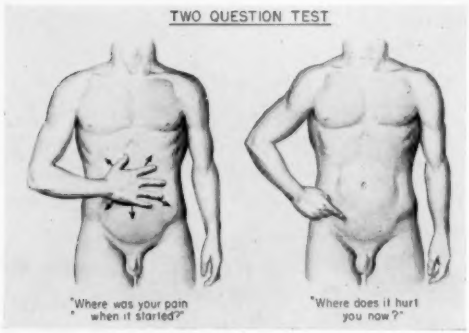

Fig. 1. The Two Question Test.

Unfortunately nausea and vomiting have been taught as being frequent symptoms. This is not true. The majority of patients neither vomit nor complain of nausea; almost all, however, have anorexia. Anorexia, nausea and vomiting are really three degrees of one symptom, being dependent upon the degree of distention in the appendix. Vomiting is associated with a markedly distended appendix, nausea with a moderately distended appendix, and since almost all acute appendices are associated with microscopic distention these patients should complain of anorexia. It is indeed a rarity to find a patient suffering with acute appendicitis stating that he is hungry.

Constipation is the rule, and diarrhea the exception. Diarrhea, however, frequently is found in children suffering with acute appendicitis; if it is present in adults it suggests a pelvic appendix with an associated periproctitis.

Physical Examination

Under this heading one routinely includes temperature, pulse and respirations. A high initial fever strongly suggests some other condition but not acute appendicitis. The fever is usually of low grade in early appendicitis but as the disease progresses, especially after the first twenty-four to forty-eight hours, the fever begins to rise as the peritoneal cavity becomes soiled. One, therefore, should not wait for fever to develop since it indicates a complication rather than acute appendicitis per se. This rule does not apply to children, since they will develop a hyperpyrexia at the slightest provocation. The pulse is seldom of great diagnostic value. The so-called diagnostic ratio should be kept in mind, namely, that for every degree rise in temperature there is a ten beat increase in pulse. The respiratory rate is normal or roughly proportional to the fever; as peritoneal soiling progresses it increases. The patient with an uncomplicated acute appendicitis usually does not appear to be seriously ill; in fact, his appearance may be quite misleading as he walks into the doctor's office. Rarely have I found these patients lying in bed with the right knee raised as is described so routinely in many textbooks.

To discuss the tremendous number of specific signs which have been associated with the diagnosis of this condition is not only exhaustive but exhausting; they have little or no practical value. To describe Bastedo's sign, Klemm's sign, Walkowitsch's sign, Reder's sign, Aaron's sign, Morris' sign, and many others too numerous to mention is only a display of academic muscle. Only those few signs, or tests, which are of practical value will be evaluated.

McBurney's Point: This is the point of maximum tenderness as determined by the pressure of one finger. It is located in the following way: a line is drawn between the right anterior superior iliac spine and the umbilicus; this line is trisected. McBurney's point will be found where the lateral and middle thirds meet. A state of confusion seems to exist as to whether this point remains fixed regardless of the position of the appendix. Although it has been stated that the nerve endings of the eleventh and the twelfth dorsal segments are reflexely irritated by an inflamed appendix, practical experience suggests that the true point of tenderness is dependent upon the position of the appendix and not the fixed nerves.

Right Rectus Rigidity: Increased tonus of the abdominal muscles, or so-called rectus rigidity, is not a sign of acute appendi-

citis, but rather a sign of peritonitis. We know that it is quite impossible to contract one rectus muscle without contracting the other. Why then do we refer to the sign as right rectus rigidity when both recti contract? To correctly test for this sign the examiner must place both of his hands on the abdomen, one on each rectus muscle. With gentle pressure he determines whether or not one rectus is rigid and the other relaxed. If such a condition exists and only one rectus muscle is found to be rigid, then this suggests a mass underlying the rigid rectus. Such masses in the case of acute appendicitis would be either a localizing inflammatory appendical mass made up of appendix, terminal ileum and omentum, or an appendical abscess. When both recti are rigid it denotes a muscular defense in response to an underlying peritonitis. Should such a rectus suddenly be released the patient will wince because of so-called rebound tenderness (Blumberg's sign).

Iliopsoas Sign: This is not a diagnostic sign for acute appendicitis, but rather one which locates an inflamed appendix lying retrocecally and involving the fascia which covers the psoas muscle. It is conducted in the following way: the patient is placed on his left side and the right thigh is fully extended (Fig. 2). If pain over the appendical area is produced by this maneuver the test is considered positive.

Obturator Internus Sign: This sign, too, locates an acutely inflamed appendix but does not diagnose it. It is performed by bending the knee and internally rotating the flexed thigh. This maneuver places the obturator internus muscle through its full range of movements and will cause hypogastric pain if an acutely inflamed appendix overlies its fascia (Fig. 3). Pelvic inflammatory disease as well as an acute pelvic appendix can produce a positive obturator sign.

Rovsing's Sign: This sign is considered positive when pain over McBurney's point is produced by exerting pressure over the descending colon (Fig. 4). Supposedly it is due to a retrograde inflation of the cecum when colonic gas is forced from left

Fig. 2. The Iliopsoas Sign.

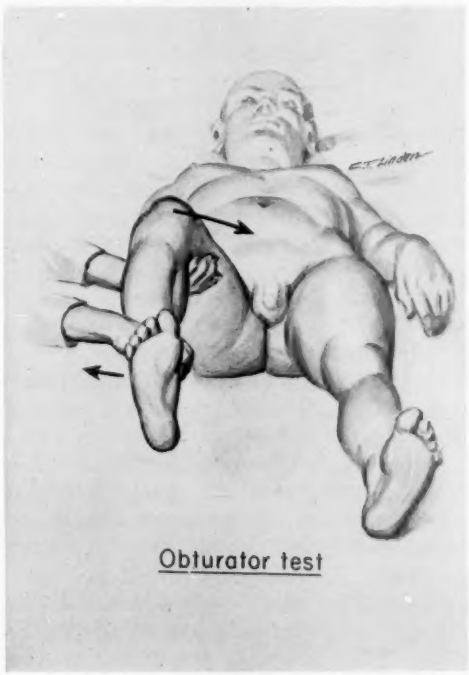

Fig. 3. The Obturator Sign.

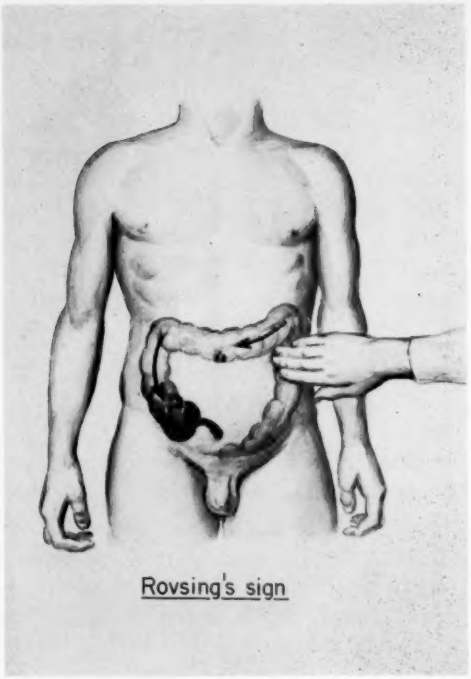

Fig. 4. Rovsing's Sign.

to right in the presence of an inflamed appendix.

No physical examination is considered complete without a rectal or so-called bidigital examination. The latter is done, whenever possible, by placing the index finger in the vagina and the middle finger in the rectum. This will readily identify the cervix or adnexal pathology, a bulging cul-de-sac of Douglas, or fecal masses. Thus greater orientation is obtained than is possible with a rectal or bimanual examination.

Laboratory Data

The laboratory data are helpful adjuncts in the diagnosis of acute appendicitis; however, they do not replace a carefully taken history and a well conducted physical examination. The differential blood count is at times more helpful than the total blood count; however, both of these are done routinely. Urinalysis is also a necessary procedure but may be misleading. If the inflamed appendix is located near or on the bladder, the ureter or the kidney, a few red cells may appear in the urine, thus masking the picture. On the other hand, a rather large ureteral calculus may plug the ureter so thoroughly that no pus or blood can pass into the bladder and again the clinician is misled. Of late we have utilized the flat x-ray film of the abdomen in those cases where the diagnosis is somewhat uncertain. Much work has been published regarding the isolation of fecaliths in the appendix as shown on sterescopic views. This is helpful both in the direct and the differential diagnosis and should be kept in mind. There are numerous other laboratory tests which have been described, but these are of little or no practical value.

Differential Diagnosis

Although a tremendous number of diseases have been confused with acute appendicitis, for practical purposes, one must be thoroughly conversant with the usual conditions which cause the greatest diagnostic difficulties. The vast majority of our errors are found in the following five conditions: acute gallbladder disease, perforated peptic ulcer, renal colics, salpingitis and acute pancreatitis.

Acute gallbladder disease is more common after the age of forty. The gallbladder patient is usually the fair, fat and forty type of individual with a history of selective dyspepsia and/or a previous similar attack. The pain is usually above the umbilicus and the tenderness is localized to the right upper quadrant of the abdomen. At times Head's zones of hyperesthesia will reveal the hyperesthetic area above the umbilicus and to the right, whereas such an area is found below the umbilicus in acute appendicitis. The pain is much more severe in acute cholecystitis and the patient usually requires sedation (this is most unusual in acute appendicitis).

Perforated peptic ulcer is almost always found in males. A history is elicited of a sudden dramatic attack of pain which doubled the patient up, forcing him to stop whatever he happened to be doing. Abdominal auscultation usually reveals a silent abdomen, and the x-ray demonstration of a spontaneous pneumoperitoneum is quite diagnostic. Tenderness is quite dif-

fuse, the abdomen is board-like, the patient looks more ill, and shock may be present. The pin-point perforation of the forme fruste ulcer will present a misleading picture.

Renal colics may be caused by stones, uratic debris, microscopic thrombi or a dropped kidney with a Dietl's crises. The pain is usually in the loin, radiates along the course of the ureter, and then into the inner aspect of the thigh or the genitalia. A bradycardia is very characteristic of renal or ureteral colic. Tenderness over the kidney area is usually present. Red blood cells in the urine are most suggestive. In cases where great doubt exists emergency intravenous pyelography may provide the final answer.

Salpingitis usually occurs immediately before, during or after the menstrual period. It is extremely rare after the menopause. Tenderness is usually bilateral and over the region of the symphysis; on bimanual examination the tender tube may be felt; tenderness can be produced by moving the cervix. A positive cervical or urethral smear is pathognomonic.

Acute pancreatitis may be either the mild edematous type or the fulminating hemorrhagic type. The pain can be diffuse or it may be located in the back; in the latter case it is usually relieved by sitting up or lying prone. Shock is present early and the pain is extreme. A high blood amylase test corroborates the diagnosis.

Treatment

That the modern advances in chemotherapy have somewhat altered the treatment of acute appendicitis cannot be denied. Regardless of this fact, however, two schools of thought still exist. One group is of the opinion that acute appendicitis is a surgical condition whenever and wherever seen; the other group advocates conservative therapy in the so-called late or neglected case of acute appendicitis. A practical middle of the road type of therapy can be applied which incorporates some of the tenets of both groups (Fig. 5). It is always preferable to remove the leaking focus from the peritoneal cavity; however, there are times

THE TREATMENT OF ACUTE APPENDICITIS

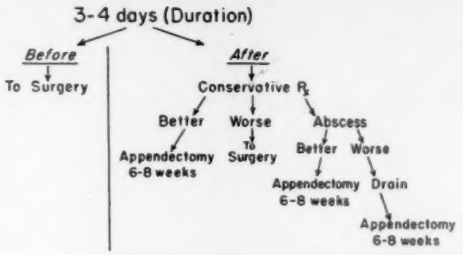

Fig. 5. A Plan of Treatment for Acute Appendicitis.

and situations when this cannot be accomplished.

A neglected so-called "three or four day appendix" may be associated with a diffuse peritonitis or an early well defined appendical mass. In these two instances the mortality can be lowed if conservative therapy is instituted. Formerly, conservative therapy meant the Oschner-Sherron regime, namely, Fowler's position, little or nothing by mouth, heat or cold to the right lower quadrant and sedation. Today, however, chemotherapy plays a major role; most cases receive penicillin for its effect upon the streptococci and staphylocci, and streptomycin which affects the gram negative rods. The sulfonamides, aureomycin and chloromycetin also have their advocates. Fowler's position has been discontinued in many clinics; I prefer to let the patient lie in any position in which he is most comfortable. The use of heat or cold over the right lower quadrant is purely a personal problem; either may be used since they act as counter irritants which relieve pain, rather than having a direct bearing upon the appendical pathology per se. In the presence of gastric or small bowel distention gastric siphonage or intestinal intubation is indicated. Protein, carbohydrates, electrolyte, water and vitamin balance must be maintained. Plasma and blood are indicated at times. Sedation is necessary; however, full doses of morphine may mask the picture, hence I prefer sedatives of a milder nature.

Under such a regime the neglected case of acute appendicitis will do one of three things: (1) it will get better, (2) it will get worse, and (3) it will form an abscess.

There are many ways of determining whether a patient is getting better or worse, since changes in pain, distention, temperature, vomiting and abdominal sounds are all of diagnostic value. However, the one outstanding prognosticator is the pulse. A rule that I have followed and one which has served us well is the following: if the pulse increases twenty beats within an hour and continues to rise, surgical intervention is indicated. This should not be confused with a rapid pulse, in which case conservative therapy is still continued. The pulse is a more sensitive and more accurate indicator than all of the other signs.

If the condition should subside and the patient's condition improve, surgical intervention is delayed for six to eight weeks. To attempt to do an appendectomy eight to ten days following a fulminating inflammatory process is to encourage wound infection, herniation, adhesions, fecal fistulae and intestinal obstruction. On the other hand, I feel that it takes approximately six weeks for the average inflammatory edema to disappear. If one waits during this interval and then has the patient return for an interval appendectomy the surgery is simple technically, and the postoperative course is usually uneventful. That the patient might have another attack within this waiting interval is possible but most improbable.

If, under conservative treatment, the patient gets worse, the surgeon is forced to operate; these are the cases which are associated with a high mortality. Surgical intervention is considered in the hope that the leaking appendix might be removed. However, these late neglected appendices are usually necrotic and ofttimes cannot be removed; if removal is possible it may have to be done by morcellation. The question as to whether drainage is correct or incorrect in such a case is still controversial. I lean toward the school of thought which believes that the peritoneal cavity is only a potential cavity, and therefore cannot be drained. It has been my custom, therefore, to close these abdomens without drainage.

The third possibility under conservative treatment for the neglected appendicitis is the formation of an appendical abscess. This is suspected when the patient presents a spiking type of fever, chills, sweats and a leukocyte count over 20,000. Should such an abscess form it may get better or it may get worse. If resorption takes place and the inflammatory mass diminishes in size the patient's condition will improve and the mass will disappear. Such a patient is permitted to leave the hospital and is advised to return in six to eight weeks for an interval appendectomy. If, however, the mass enlarges and the patient's condition gets worse the abscess is incised and drained. If the appendix is found in the abscess cavity (this is most unusual) it is removed; if it is not found, an interval appendectomy is performed six to eight weeks after drainage of the appendical abscess. Auto-appendectomies have been reported, but these too are quite infrequent.

This plan does not apply to children suffering with acute appendicitis, since it has been shown that children do not have the ability to localize acute appendical lesions. Therefore, in children, the rule must be followed that the case is a surgical one regardless of the time element.

Technical Aspects of Appendectomy

The choice of the incision, whether a McBurney or a rectus, will be determined by the type of case and the surgeon's prefence. To spend a great deal of time locat-

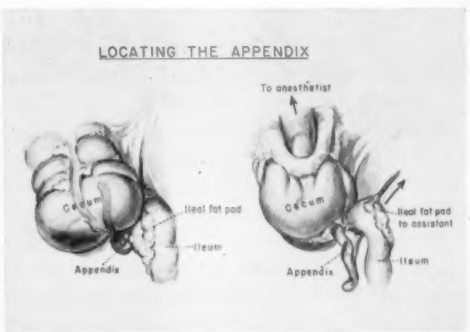

Fig. 6. Surgical Anatomy as an Aid to Locating the Appendix. The appendix is retrocecally placed in over 70 per cent of individuals. The terminal ileum as it leaves the pelvis to join the cecum runs parallel with the cecum and not at right angles to it. The terminal ileal fat pad usually hides the appendix.

ing the appendix can cause much embarrassment to the surgeon and postoperative discomfiture to the patient. Congenital absence of the appendix is indeed a rarity since this has been estimated to be present in one out of every 100,000 individuals.

At times it might be difficult to locate the appendix; however, by following two simple maneuvers the vast majority of appendices can be found readily (Fig. 6). The cecum is picked up in a moist laparotomy sponge and gently pulled upward toward the anesthetist. The terminal ileal fat pad (a neglected bit of anatomy which is an excellent surgical guide) is grasped with a Babcock forceps and handed to the assistant at the opposite side of the table. These two simple maneuvers will result in bringing the appendix immediately into view in 85 to 90 per cent of cases. Since over 70 per cent of appendices normally lie retrocecally and since the terminal ileum and its fat pad run parallel with the cecum the rationale of these two maneuvers is apparent.

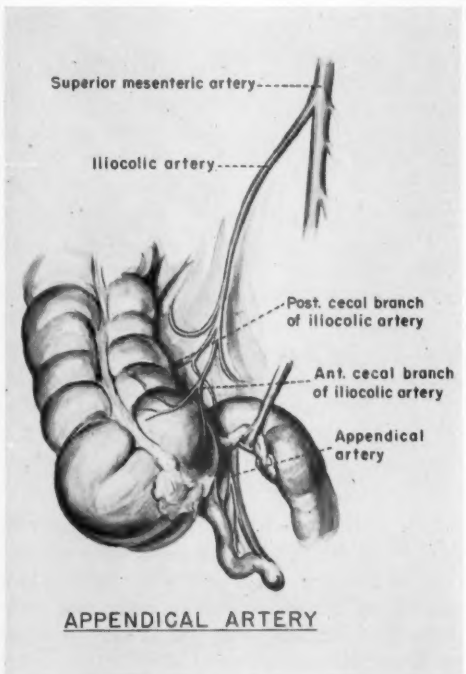

Fig. 7. The Surgical Anatomy of the Appendical Artery. The appendiceal artery passes retro-ileally and not retrocecally.

The anatomy of the appendical artery should be emphasized if the serious complication of intra-operative hemorrhage is to be avoided (Fig. 7). The appendical artery arises from the posterior cecal branch of the ileocolic artery. The artery to the appendix does not pass retrocecally, but takes a retro-ileal course. If, therefore, hemorrhage from a slipped appendical artery should take place during the course of an appendectomy the ileal fat pad should be raised and the bleeding point searched for behind the terminal ileum. Retrocecal search for such a bleeding vessel will fail to reveal the source of hemorrhage.

Many methods of management of the appendical stump have been described; these, too, must remain a personal problem until definite evidence can be produced to substantiate the claim that one method is definitely superior to all the others.

Summary

1. The mortality of acute appendicitis still remains high.

2. The Two Question Test has been useful in correctly diagnosing most cases of acute appendicitis.

3. The fallacy of right rectus rigidity as a diagnostic sign is discussed.

4. The iliopsoas and obturator signs are stressed as signs which locate rather than diagnose an acute appendicitis.

5. A simple method of locating the appendix is presented.

6. A plan of treatment is presented which includes the management of both the early and the neglected case.

Sixth Biennial Rocky Mountain Conference at the Shirley-Savoy Hotel, Denver, May 9, 10 and 11. You'll want to plan now to attend this Conference. An excellent program has been arranged. Details are in the colored section of this issue. The guest speakers will include: Drs. J. Vernon Luck, Los Angeles; George M. Curtis, Columbus; Frank Pray Foster, Boston; Louis A. Buie, Rochester, Minn.; Donald G. Johnson, New York; John A. Anderson, San Francisco, and M. T. Van Studdiford, New Orleans.

DIAGNOSIS: PSYCHONEUROSIS — WHAT HAPPENS NOW?*

JOHN M. LYON, M.D.
DENVER

During the last few years physicians have become more and more aware of emotionally determined illnesses. The literature has included an ever increasing number of articles devoted to the psychoneuroses, and we now seem to have arrived, more or less, at a point where most physicians can identify those patients who have psychogenic disorders. Such recognition, however, has served to raise an even more difficult situation, namely, what does one do after the diagnosis of a psychoneurosis is made.

This paper is not designed to expound upon psychotherapy for there are several areas that need examination before psychotherapy is undertaken. For instance, a physician who has arrived at a diagnosis of psychoneurosis may realize that his problems have just begun. To announce or even hint at the diagnosis may make the patient angry, and yet how can treatment be started if the patient refuses to acknowledge his disease? For the physician to state that there is nothing wrong with the patient rarely if ever satisfies, and it must be admitted that even the best motivated explanation of how emotions can cause symptoms usually is a dismal failure. Yes, the diagnosis of a psychoneurosis can pose more trouble than it is worth, and unhappily this accounts for the fact that even though physicians are alert to the prevalence of psychogenic disorders they understandably are reluctant to make such a diagnosis except as a last resort. Before proceeding to positive points an analysis of what is being done is in order for if physicians can have an understanding of their own behavior they are in a better position to improve upon it.

Referral to a Psychiatrist

Referring a psychoneurotic patient to a psychiatrist might seem at first glance to be the simple solution. Obstacles immediately come to light. First there may be no psychiatrist within hundreds of miles or all available psychiatrists may be so busy that the patient is forced to wait for several weeks before he can be seen. Then comes the practical problem of expense. Many patients in need of psychiatric care are not medically indigent but neither can they afford private psychiatric care for an extended period of time. If these obstacles do not exist there are even greater ones awaiting. The physician, to make a successful referral, is going to have to discuss it with his patient. This may be a ticklish affair and again may cause the patient to react with great heat or feel he somehow has been insulted. The patient who reacts with hostility may well seek out another physician, and the second physician may remove a gall bladder or a uterus which brings about temporary improvement. The implications need no elaboration.

Then there are those patients who will accept the referral to the psychiatrist but only because they are desperate for relief or have such a good relationship with their physician that they would never think of disobeying him. Most of these people do not accept the emotional etiology of their symptoms and they meet the psychiatrist disavowing all responsibility for the visit. Their attitude is one of "Dr. X sent me and here I am. Now make me well if you can." Few psychiatrists have any real success with this type of patient so the patient returns to his physician in a triumphant mood. He has been to see the psychiatrist, received no help, and therefore feels his symptoms must be physical just as he has always contended.

Physicians who have had experience with the above described situations have an understandable distaste for repeating them, and again it is easier not to make the diagnosis of psychoneurosis. Certainly the topic of a psychiatric referral will be handled with caution and only with selected patients.

*Read at the Regional Meeting of the American College of Physicians, Denver, Colorado, February 21, 1950. The author is Professor of Psychiatry, University of Colorado School of Medicine.

Avoiding the Diagnosis by Finding Physical Pathology

When the diagnosis of a psychoneurosis has so many unhappy accompaniments it is only reasonable that a physician will wish to avoid it both consciously and unconsciously. Therefore, if the examining physician can find some type of organic pathology he will welcome such a find. By his concentration on this perhaps asymptomatic bit of pathology he keeps himself from recognizing the personality fault and thereby avoids the troublesome area in which he is ill-equipped to work. Diligent searching for physical pathology does sometimes turn up unexpected finds but more often in the psychoneurotic patient it takes on the aspects of a witch hunt and results in an unjust accusation of some relatively innocent organ. Such procedures have led to the coinage of the word "iatrogenicity," meaning doctor caused illnesses, and account for a large number of psychoneurotic people who have organic diagnoses firmly implanted in their thinking.

This same line of reasoning combined with the old "either, or" philosophy will also explain why people with real organic disease rarely have a concomitant emotional disorder recognized until it has assumed severe proportions. It isn't that a physician wilfully ignores the possibility of an emotional disorder, it just doesn't occur to him if the patient has organic disease.

Viewing the Diagnosis as Being Associated Only With Disagreeable People

The unpleasant aura that surrounds psychiatric disorders has led many physicians to feel that only unpleasant people have psychoneuroses. If a patient is cooperative, productive in his work, appreciative of the physician's efforts, and pays his bills, some physicians just cannot bring themselves to consider the possibility of a psychoneurotic disorder. The statement of "he is a nice fellow" is used all too frequently to rule out the possibility of an emotional disturbance. Let the patient be irritable, demanding, and critical and a diagnosis of a psychoneurosis is no problem at all. The truth is that there are likable psychoneurotics and unlikable ones, and pleasant cooperative behavior may only be a sign of deep neurotic needs, but it is much easier for a physician to incur the wrath of someone he doesn't like. There is also a perverse pleasure in seeing a disagreeable patient depart especially if the physician seems incapable of instituting successful treatment. This one-sided viewpoint probably accounts for the fact that many physicians do consider psychoneurotic patients all to be disagreeable for those are the only kind they ever recognize. At any rate by refusing to diagnose the likable, productive patient as a psychoneurotic, the problem of treating him is greatly simplified. The unfortunate part consists in the fact that the treatment will be misdirected and the patient's basic neurosis reinforced. Such a patient's search for a medical cure can go on for years until his lack of response to treatment finally makes him suspect. It is only human nature that physicians should like the patient they can help and dislike the ones they cannot. There is also some personal satisfaction to be gained by labeling a disagreeable patient a "neurotic" whether he has organic disease or not.

Compromise

There are those situations when a physician knows full well that he is dealing with a psychoneurotic patient. For one or more of the reasons mentioned above he decides not to announce the diagnosis. He makes a compromise with himself in that he will not subject the patient to any rigorous or expensive treatment but he will give some vague innocuous diagnosis and carry the patient along on a supportive regime of vitamins, sedatives, and laxatives. This scheme will work for some very mild cases of psychoneurosis and it may be more or less satisfactory for a short time for more severe cases. In the great majority of cases, however, the patient will not show any lasting improvement and his rising dissatisfaction with his treatment will lead to unpleasantness. It may force the physician into a laboratory hunt for disease or even into treatment that he knows is not warranted.

There is another complication to the com-

promise method of treatment. The fact that a diagnosis has been made and treatment prescribed even though it was vague and innocuous is a thing that will stick in the mind of the psychoneurotic patient for years to come. All physicians who see that patient in the future will have to contend with diagnoses of anemia, gastritic, colitis, chronic appendicitis, sinusitis, etc. If the patient's neurosis is severe enough to be interfering with his desired way of life he is in need of help, but his solidified belief in organic disease makes his treatment all the more difficult.

Refusing to Allow the Patient to Talk

Another method of avoiding trouble is to refuse to hear about trouble. Most physicians know that they are supposed to listen to a psychoneurotic's story, but sometimes after listening to a tale of woe the physician finds himself wishing he had never heard it. Having heard the tale of emotional upset the physician feels called upon to do something about it, and yet just what it is that he is going to do is beyond him. More than one physician has thought or has actually said, "Why do you tell me all this; there is nothing I can do about it." The desire to keep from hearing about emotional upsets may account for so many physicians insisting that they control the interview with a rigid question and answer routine. Such a method precludes any spontaneous productions and allows only material to appear that the physican feels capable of handling. It is surprising but true that most people feel that a physician does not want to hear personal affairs and they usually become suspicious the moment a physician shows any such interest. By refusing to show interest and by preventing spontaneous productions the physician feels he can steer clear of trouble. This technic, needless to say, may not allow the correct diagnosis and certainly will not help the patient to get well.

Getting the Patient to Accept an Emotional Etiology

Lastly there are those instances where a patient will pour out a story of personal conflict but refuses to see any connection between his plight in life and his illness. It is at times almost unbelievable the way a patient will refuse insight into the cause of his symptoms. Such a patient usually chooses to view his stated physical impairment as an added blow of fate when he already was having more trouble than he could handle. Or, getting the true situation just backwards, he may see his illness as a direct cause of the unpleasant situation which he reports. He will resist any other explanation. Or, he will defend an obvious nervousness by pointing out that anyone who suffers as he does has a perfect right to feel worried, jittery and upset. When the doctor adds to this burden with the diagnosis of a personality defect the patient may well feel that he made a mistake in ever revealing his personal problems. There then develops an argumentative situation between the patient and the doctor—the doctor trying to get the patient to see how the emotional upset is responsible for the symptoms and the patient trying to get the doctor to see how that couldn't possibly be the case. Nothing good can come of this.

So referral, mis-diagnosis, rejection, compromise and explanation are methods a physician can use when he doesn't know what to do with a psychoneurotic patient. None of these methods are satisfactory and few physicians will continue to use them if something better can be found. Psychiatric literature gives many suggestions on how to conduct psychiatric therapy, but the average practitioner soon finds that he cannot use these psychiatric technics on his particular group of neurotic patients without getting into trouble. There is a vast difference between the patient who consults his psychiatrist, acknowledging the emotional element of his illness, and the patient who goes to his internist for relief from what he presumes to be an organic disturbance. The great bulk of psychotherapeutic procedures listed in psychiatric literature simply do not apply to this latter patient. They do apply to the patient who wants psychotherapy or at least knows that is what he is supposed to be getting. Therefore, before psychotherapy can begin it would seem necessary to orient the patient

as to the nature of his illness. This orientation process is attempted by many physicians but if they are honest with themselves they will have to admit that they are unsuccessful in a great majority of cases. Only a very few patients will accept the emotional role of their symptoms and the remaining ones will react with definite hostility. Explanations of autonomic behavior make excellent reading for the physician but they have little effect upon the psychoneurotic. So it is often true that an honest attempt to do psychotherapy is doomed before a start can be made.

Up to now no good suggestions have been made on what can be done and yet the discussion up to this point was necessary. It must be made apparent that fairly drastic changes in accepted medical procedure must be made if a psychoneurotic patient is going to be handled successfully by the average physician. Much of the difficulty goes back to the method in which the diagnosis is made. If the doctor has concluded that the patient is a neurotic because no physical pathology was found and because of symptoms that sounded neurotic, then he makes a mistake if he announces his impression. This is making a diagnosis purely out of negative factors, and, so far as the patient is concerned, is absolutely without justification. So far as the patient knows he has done nothing and has said nothing that would warrant such an opinion, and he is justified in concluding that the physician is accusing him of having emotional difficulties simply because the physician has doubted the reality of the complaints. The patient knows how he feels and he is going to defend his symptoms and insist that they are real. If the physician feels that he must make the diagnosis he at least should wait until the patient has provided positive points to support the diagnosis of an emotionally determined illness. Probing or leading questions rarely do more than arouse suspicions, so, this means that the physician should obey one of the cardinal rules of psychotherapy and remain silent whenever a patient shows an inclination to talk.

Allowing a patient to produce spontaneous information is not a technic that is begun after a routine medical history has been taken and a physical examination completed. Instead the wise physician allows his patient complete freedom from the initial moment of contact and is willing to listen to anything the patient has to say. This ability to listen must be combined with willingness to accept whatever the patient has to say. The physician should not take exception to the patient's foolish medical mis-statements, and by all means the physician must not become huffy when the patient vents feelings of hostility towards medicine and doctors in general. Anything that is good can withstand criticism, but for some reason physicians are notoriously touchy and react with annoyance or hurt pride whenever their efforts are not appreciated. A physician can learn of many things to avoid if he will but listen to a patient's peeves and unfortunate past medical experiences.

The technic of allowing a patient complete freedom of expression is admittedly difficult for the physician who has been trained in the time honored method of taking a medical history, but with a neurotic patient it is not only superior but it is actually time saving and paves the way for future treatment. The following can almost be stated as a rule: If a patient's physical symptomatology has an emotional etiology, that patient, if given the opportunity, will sooner or later cease talking of his physical complaints and begin to talk about the personal relationships that are giving him unhappiness and may be the cause of his distress. Such a patient may have no idea that the material he is relating has any bearing on his illness but then again, some patients will show an amazing insight, and all the doctor has to do is to confirm the patient's suspicion that the difficulty lies in the troublesome emotional material that was just unfolded. The important factor, however, and one that cannot be emphasized too strongly, is that if a patient tells of difficulty in the field of personal relationships, then the physician is not making the diagnosis of a neurosis out of negative findings. Many hostile re-

actions can be avoided by letting the patient tell of his emotional upsets instead of accusing him of having them and thereby apparently refuting the reality of symptoms.

Next a clarification of the purpose of psychotherapy is needed. It must be pointed out that the psychotherapy does not consist of getting a patient to accept the emotional etiology of his symptoms. For a patient to have such an understanding is desirable but it is not necessary and is never the purpose of psychotherapy. Rather, the purpose of psychotherapy is to help a patient identify and acknowledge a source of anxiety in his personal life and then to aid him in handling this problem so as to reduce the anxiety. The connection between the anxiety producing problem and the physical symptoms may be revealed to the patient as therapy progresses, but it is not the therapist's main goal. The reduction of anxiety by helping the patient to understand his problem is the main goal and as the anxiety is reduced, the physician will be pleased to note that the physical complaints lessen in intensity or cease altogether. Many patients have made this type of recovery never having had any discussion about the connection between their emotional problem and their physical complaints.

Such an approach to the neurotic patient helps to keep the physician out of trouble. Actually, in many instances, he is carrying on two lines of treatment simultaneously; he is accepting and treating a physical complaint on one hand, and on the other, he is helping the patient with a personal problem. He avoids bringing the two together until the patient indicates that he is ready for such an understanding. Some patients will show insight quite early and others never will. Both types can be cured. The important point is for the physician to conduct himself in such a manner that the patient will bring out his personal problem and indicate a desire to work with it, and at the same time the physician avoids an organic diagnosis but he does not withhold symptomatic relief.

This orientation toward psychotherapy will keep the physician from viewing his main task as consisting of getting a patient to see the true etiology of symptoms. For a patient to know that he is nervous doesn't make him any less nervous. The whole import of "It's just your nerves" is extremely harmful, particularly if this statement is made before the patient has revealed anything about himself that would cause "nerves." "It's just your nerves" implies "it is nothing" and this is just what the average physician means when he makes such a pronouncement. The philosophy then of getting a patient to accept the emotional role of his illness is basically one of attempting to explain away the symptoms. No patient was ever talked out of feeling the effects of his autonomic nervous system unless he was hypnotized and such specific results successfully suggested. If physicians accept the reality of symptoms produced by anxiety, they never make the mistake of allowing "nerves" to become synonymous with "nothing" and therefore something that will disappear upon explanation.

We now come to another troublesome area. Doctors have long been trained to accept responsibility for the physical ills that patients bring to them, so it is not surprising that they feel they should also accept the responsibility for a patient's personal unhappiness. Physicians would be much more willing to listen if they did not feel that they had to do something with a patient's tale of woe. No physician is responsible for a patient's misspent life and no physician should feel himself called upon to extract a patient from a source of unhappiness. No one can reach out into a patient's environmental setting or reach back into early family patterns and rearrange things. Psychotherapy does not consist of solving a patient's problems for him and a physician takes on an unwarranted and impossible task if he tries. Yet, the doctor must listen to the story. The help the doctor can give is bound up with his ability to listen and when a patient feels free to talk and when a patient presents a problem of emotional concern, then, and only then, can the rules of psychotherapy that appear in the textbooks be put into use. This is not the place to discuss psycho-

therapy but it should be understood that a physician cannot help a patient with an emotional problem unless that patient has presented a problem for help and no patient can present a problem unless he is given the opportunity to do so.

The problem of referral to a psychiatrist can now be re-examined. Two points need early attention. It must be admitted that a smooth referral is not always possible either because of the severity of the patient's psychoneurosis plus the degree of iatrogenicity present or because the patient has had an unhappy previous experience with an inept psychiatrist. Either of these situations just about precludes an easy referral. There are many patients, however, who can be referred with little or no trouble if some of the suggestions already made are followed. Probably the first rule is similar to the situation of making the diagnosis, i.e., do not make a referral on the basis of negative factors. It is almost certain that a patient will react unfavorably if he has discussed only physical complaints and then is told that he needs to see a psychiatrist. The patient's interpretation of this is almost always the same. He simply concludes that the physician thinks the complaints are imaginary, all in his head, or the delusions of an unbalanced individual. Naturally people resist such an attack, and many psychoneurotics who are experiencing anxiety have already formed a vague, unspoken fear of insanity, and they will react all the more vigorously. The physician must wait until the patient has revealed something about himself. This material should be allowed to emerge as a problem and when it so appears very few patients will feel resentment when the physician suggests calling in specialized help. A referral of this type allows a physician to appear as a person who wants to help and not as a person who is rejecting and misunderstanding. Referring a patient for help with a personal problem is much easier than allowing the referral to seem to be for the relief of imaginary aches and pains.

An objection immediately arises. There are those psychoneurotic patients who do have serious personal problems but never speak of them or are actually unaware of them. It may seem inconceivable that a person could have an annoying personal problem and not know it, but such is the case all too frequently. A good example is the middle aged spinster who has spent her life caring for an aging and invalided mother. Such a person may never have allowed her thoughts to dwell on her thwarted existence and she may be totally unaware of her real feelings toward the person who was to blame. In such instances the physician needs skill and tact. First to allow enough information to come out so that he can understand what is going on and secondly to allow the patient to identify her situation in such a fashion that the physician is in no danger of seeming to be accusatory. Once the patient begins to talk about how her life has been ruined the physician is still extremely careful about pointing out her feelings toward her mother, but her problem has been presented and a psychiatric referral will be much simpler.

The above hypothetical case serves another purpose. It also gives some understanding of how a physician can help a patient by just listening to him. No one could undo the forty wasted years of the spinster's life and no one could be expected to make her like her predicament. But by allowing her to express her feelings and to get things off of her chest she will feel better. Particularly will she feel better when she discovers that the physician can understand and appreciate her feelings and that the physician does not think her feelings are foolishness. The physician does not complicate things by trying to drive home the point that the spinster's situation is responsible for her physical symptoms for he knows full well that such understanding will not make the situation disappear and therefore will not bring about a relief of symptoms. The symptoms will improve as the patient's feelings get some expression and as she gradually works out with the physician the best way of handling her unhappy position at home.

The physician who wishes to help psycho-

neurotic patients will find that the suggested procedures are not difficult; they are just different. No physician should feel that he is supposed to be able to help all psychoneurotic patients for some psychoneurotic people, like some organic cases, are beyond help. No physician should be fearful of hearing a patient's story, and it is no problem to get a psychoneurotic patient to talk. After adopting a permissive, passive attitude the physician instead of asking "How do you get these people to talk?" will be wondering "How do you get them to shut up?"

EXPERIENCES WITH ANTABUSE*

PRELIMINARY REPORT

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This report on Antabuse (tetraethyl thiuram disulphide) is based on observations covering the period May 20, 1949, to May 20, 1950, with twenty-six patients selected from the total group of admissions for alcoholism during the past year. At the time of this writing, the treatment procedure has been initiated and stabilized for all but six of the twenty-six patients. Vital statistics for the group include the following notations: seven of the twenty-six patients were female; the age group was roughly that from 30 to 50 years with but one patient under 30 years of age; eight of the twenty-six patients were from states other than Colorado; five patients had no home or family to return to following their treatment program; eleven patients had family situations which were not considered optimum, return to which constituted some threat to the patients; twenty patients had entered the hospital on a voluntary basis; six of the patients were admitted to the hospital by virtue of a court order to confine and treat; seventeen of the twenty-six patients were married, three were single, five were divorced, and one was a widow. All patients were potentially productive citizens but drinking habits were fully disabling; six of the group were well above the average in financial means and opportunities; two of the group were admitted and treated under the auspices of the County Welfare Department; five of the group were veterans of World War II.

Physical and neurologic examination found the group to be in a state of excellent health, collectively. One patient was diagnosed as a pulmonary coccidiomycosis of non-disabling degree, and three patients disclosed histories revealing a convulsive status during previous withdrawal periods associated with drinking. Preliminary or prerequisite examinations for these patients included a physical and neurologic examination, a clinical psychiatric examination, with psychologic testing where indicated, and routine studies, including uranalysis, blood count, sedimentation rate, blood Kahn, chest x-ray, liver and renal function tests. Electroencephalograms were afforded those patients for whom such a procedure was indicated. During the course of the year, these examinations precluded administering Antabuse to approximately five patients; one rejectee has subsequently died.

Classification by diagnosis psychiatrically discloses fourteen of the group listed as neurotic in personality makeup; eight would qualify as psycopaths. There was one schizophrenic. Four of the neurotic patients presented schizophrenic Rorschachs. All patients were average or above in I.Q.

Administration of the drug was carried out as suggested by the distributor* and included a period of detoxification, varying from three to ten days, a period of hospitalization during preliminary trials of alcohol, varying from six to fifty-six days, including trials varying in number from three to twenty-three. Laboratory rechecks

*Presented to the Colorado Neuropsychiatric Society, Emory John Brady Hospital, Colorado Springs, Colorado, May, 1950.

*Ayerst McKenna & Harrison, Ltd.

were accorded the patients at intervals of one, two and four weeks. There appeared no correlation between the success of the treatment and the number of trials with alcohol.

Administration of the drug was readily accomplished in the hospital situation. A total of ninety trials with alcohol were accorded the twenty-six patients, without untoward incident. Two patients have disclosed convulsive phenomena, after starting on the medication, but were enabled to continue the medication after a brief respite during which time they were placed on a dilantin-phenobarbital regime. One patient sustained an allergic reaction, which, however, was not fixed, responded to benedryl and did not reoccur when the dosage of Antabuse was diminished. Liver and renal function tests disclosed no variations worthy of remark. There were no major changes in personality status, although the families of certain of the successful patients could be described as somewhat elated with over-all results.

Results of the treatment program are still being tabulated. Today, three of the twenty-six patients have sustained relapses; however, one of the three has returned to Antabuse and is successful at the present time, with approximately six months' abstinence from drinking. A total of six failures has been established, which include the two relapses. One patient who relapsed from the use of Antabuse, and who is no longer taking the drug, has also discontinued the use of alcohol and, at the present time, is in her fourth month of abstinence.

In conclusion, some interesting corrolaries can be pointed out. Of the six failures, five were either unable, unwilling, or were deprived of the opportunity of paying for their treatment and hospitalization. But one of the failures was female. Four of the patients admitted under court order and who initially were reluctant to take the medication have since that time been successfully abstinent. One of the six failures produced a schizophrenic Rorschach. Treatment for three other patients with similar Rorschachs has been successful. At the present time, there seems to be no known criterion or basis on which to predict a successful or unsuccessful Antabuse experience. A review of our data to date discloses the fact that no harm has been done to any patient, whereas approximately 70 per cent of the patients so treated have definitely been helped.

The difficulty in follow-up associated with out of state patients and the safe provision to them of adequate supplies of the drug continues to pose a problem. It is felt that with wider acceptance of the procedure, general practitioners can successfully maintain the treatment program. The question of the need for continued psychotherapy varies with the individual patient. The total period indicated as a treatment experience has not been decided, nor can the medication be accepted as safe beyond the twelve-month scope of this paper. It is felt, however, that Antabuse properly administered is not a harmful substance and that the measures to safeguard patients can be greatly relaxed and treatment accorded them at greatly reduced expense.

Summary

Twenty of twenty-six patients were successfully treated with Antabuse over a twelve-month period. There were no harmful sequelae. The procedure is the most successful treatment for chronic alcoholism as yet used in this clinic.

FACTS ABOUT POLIO

Polio is caused by a virus. The virus probably enters the body through the mouth. In some people, it may then attack the nervous system. When the nerves are injured by the polio virus, muscles are weakened. Often the nerves get well again, and there is no paralysis.

More people have polio in the summer and fall than in other months of the year. Polio is catching, especially for children under 10, but people of any age can get it. Many people have the polio virus in their bodies without becoming ill. It is found in the throat and intestines. It usually takes seven to fourteen days to come down with polio after infection by the virus. When polio is in the community, doctors believe it is better to put off tonsil and adenoid operations, if possible.

Case Report

FOREIGN BODY IN THE BLADDER OF A CHILD WITH STONE FORMATION*

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Recovery of foreign bodies from the human bladder has been frequently reported in medical literature. Every conceivable object small enough to be pushed through the urethra has been removed.[1 2 3 4] Among adults this phenomenon is more commonly encountered than among children. A review of literature for the past fifteen years disclosed only one case similar to the one to be reported[6].

The variety of methods whereby the foreign object finds its way into the bladder is limited. Among these the following may be briefly mentioned: Trauma incidental to warfare, industry, and play; trauma associated with surgery on, in, or in the vicinity of the bladder; and by far the most common is that where the individual forces the object through the urethra. Masturbation in the adult and curiosity in the child are the impelling forces that prompt this erotic and painful indulgence.

The symptoms that accrue from a foreign body in the bladder are, in a measure, dependent upon the consistency and shape of the object and the length of time intervening between the entry of the object into the bladder and its discovery. A hard and sharp object will provoke symptoms early, whereas a soft or smooth object may not make its presence evident until rough calcareous material is deposited on it. Just how long it takes for salts of calcium and phosphorous to envelope the foreign object depends upon the type of infection associated with the process, the extent of irritation produced, the tendency for accumulation of stagnant urine, and upon disturbance of normal metabolic processes. Calcareous deposits about the foreign body have been noted in a matter of days and in some cases years elapse before stone formation makes its appearance.

The symptoms that follow a foreign body in the bladder are associated with the pathology it produces. The most frequently cited complaints are suprapubic pain and/or perineal discomfort, increased urinary frequency, urgency, interruption of the stream, stranguria, pyuria and terminal or total hematuria. The pathology produced, as observed through the cystoscope, simulates closely that associated with acute, diffuse, fulminating cystitis. The mucosa is dusky red, edematous, with areas of bullous edema often encountered. With the persistence of the irritation and infection, the pathologic process extends beyond the mucosa, producing the small contracted and highly irritable and hypertonic bladder, which accounts for the increase of urinary frequency. The terminal pain and hematuria are accounted for by the forceful and spasmodic contraction of the bladder wall on the foreign body as it reaches the point of complete emptying.

Diagnosis is not always simple. The history in these cases is often confusing and misleading. The adult presenting himself with the complaint of cystitis distorts the true history of the case because of shame and the child because of fear or the inability to associate the symptoms with the indiscreet act that preceded them. The inaccuracy of the history is invariably overcome by cystoscopy and x-ray studies. These two methods establish the diagnosis beyond any doubt.

Once the diagnosis is established, treatment is categorical. Urologists uniformly agree on the prompt removal of the foreign body, but there is a variance of opinion as to the method used. The factors which often influence the opinion of the operator are the size, shape, and consistency of the object, the position of the object in the bladder, the time that intervened between the entry of the object into the bladder and the establishment of the diagnosis, the condition of the bladder, the amount of calcareous deposits covering the object and, finally, the status of the patient. The trans-

(Continued on Page 279)

*From the Department of Urology of St. Anthony Hospital, Denver.

Sixth
Rocky Mountain
Medical Conference

MAY 9-10-11, 1951

SHIRLEY-SAVOY HOTEL
DENVER, COLORADO

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A Joint Enterprise of the

Colorado State Medical Society

Montana Medical Association

New Mexico Medical Society

Utah State Medical Association

Wyoming State Medical Society

THE R. M. M. C.

What It Is—What It Does

There are many current medical organizations which call themselves "conferences." Here we have at least one, the Rocky Mountain Medical Conference, that is truly what its name implies. For it is not an organization. It is a biennial conference, a self-sustaining joint enterprise of five state medical societies.

The Rocky Mountain Medical Conference is, we believe, unique in medical society enterprises. It was first suggested in 1935 by Dr. George P. Lingenfelter, Colorado's fraternal delegate to New Mexico, Utah and Wyoming. Colorado, Utah and Wyoming jointly decided to undertake such a conference and New Mexico joined within a year. The first meeting was held in 1937 in Denver, with the Colorado Society as host. At that meeting permanent policies were fixed for the future of the Conference, and these policies have been adhered to ever since. Montana joined the Conference in 1939 at the time of the second meeting in Salt Lake City.

Basic principles of the Conference include several "don'ts." This Conference elects no officers, and indulges in no medical politics. It is pledged to consider no resolutions or pronouncements relating to the policies of organized medicine. It forbids itself any activities that would aggrandize an individual, state or locality. Its sole purpose is to meet every two years to bring Rocky Mountain physicians together for an outstanding scientific program featuring speakers of national stature from outside the Rocky Mountain Region—and to bring them together for renewal of their regional friendships. Its meeting place is rotated among the participating states.

Management of the Conference is vested in a "Continuing Committee." Each participating State Medical Society has organized a Conference Committee of five of its members, serving overlapping five-year terms. These committees, together, constitute the Continuing Committee, which meets at least annually to plan future programs and manage the affairs of the Conference. The chairman of the host state's Conference Committee is Chairman of the Conference to be held in that state. He selects a Secretary-Treasurer for that particular meeting and with the help of the Continuing Committee also selects the several sub-committees needed to plan the meeting for which his state is host.

The first meeting of the Conference, in 1937, established an enviable reputation among medical meetings for the quality of its program, its fraternalism, and its precise conduct. The second meeting, in 1939 with Utah as host, advanced the ideals of the first. The third was held in 1941 in Yellowstone Park with Wyoming as host and proved that this type of meeting could be held far from centers of either medical or general population and still attract the best in the nation. World War II forced postponement of the fourth meeting, but when it was held in 1947, in Albuquerque, it was evident that the spirit of the Rocky Mountain Medical Conference was as strong as ever.

The fifth conference, in Butte, Montana, in July, 1949, completed the first rotation of these meetings among the five participating states. A combination of unfortunate circumstances over which neither the Conference nor the Montana Medical Association had control (particularly a hotel and restaurant strike) cut attendance at the 1949 meeting far below expectations, but all who took part proclaimed it an outstanding program.

The Rocky Mountain Medical Conference now returns to its birthplace, Denver, for the sixth or 1951 meeting. Those who have studied such meetings believe that this meeting of the Conference should break all attendance records, especially in view of the fact that full-color television will be featured—this being only the second time that color television of medical and surgical procedures has been shown in the Rocky Mountain region.

REGISTRATION AT R.M.M.C.

Registration at the Rocky Mountain Medical Conference is open to any Doctor of Medicine who is a member in good standing of his State Medical Society. Registration is not limited to physicians within the five states which participate in managing the Conference.

The registration fee for the sixth meeting of the Conference at Denver is ten dollars. The registration fee does not apply to members of the physician's family who may accompany him to the meeting. Each physician will be given an identification badge, and admission to all Conference activities will be by badge only. Separate tickets will be on sale at the registration desk for the banquet and dance.

Any physician who is not a member of his State Medical Society may register on payment of the regular ten-dollar registration fee plus a penalty fee of five dollars. In such cases, the additional five dollars will be remitted by the Conference direct to the appropriate State Medical Society and will become the property of that society. Should that society's regulations permit and should it be mutually agreeable to the doctor and that society, the five dollars may be considered as a payment on account, in case of delinquency, or as an advance partial payment of dues in the event of an application for membership.

Program

Biennial

ROCKY MOUNTAIN MEDICAL CONFERENCE

Shirley-Savoy Hotel
Denver, Colorado
May 9, 10, 11, 1951

TUESDAY, MAY 8

All day—Advance Registration and Installation of Exhibits at Hotel.

Evening—Stag Smoker and Entertainment. (Details to be announced in final program.)

WEDNESDAY, MAY 9

MORNING

8:00—Registration and Exhibits Open.

George P. Lingenfelter, M.D., Denver, Chairman, Rocky Mountain Medical Conference, Presiding.

8:30-10:30—Full-Color Television, Surgical Clinics.

Direct, full-color television of medical and surgical procedures telecast from the Denver General Hospital to special receivers in the Lincoln Room of the Shirley-Savoy Hotel through cooperation of Smith Kline and French Laboratories. (Separate programs of television clinics will be distributed at the time; also see tentative schedule on a later page of this issue.)

10:30-11:00—Intermission.

11:00-11:30—John A. Anderson, M.D., San Francisco, Professor of Pediatrics, Stanford University of Medicine—"Diagnosis and Treatment of Bulbar and Respiratory Poliomyelitis."

11:30-12:00—J. Vernon Luck, M.D., Los Angeles, Orthopedic Surgeon—"Acute and Chronic Skeletal Infections Since the Antibiotics.

12:00—Recess.

AFTERNOON

Ervin A. Hinds, M.D., Denver, President, Colorado State Medical Society, Presiding.

1:00-3:00—Full-color Television: Medical Clinics.

3:00-3:30—Intermission.

3:30-4:15—Martin T. Van Studdiford, M.D., New Orleans, Professor of Dermatology, Tulane University—"Nummular-like Dermatoses and Sensitizations."

4:15-5:00—Donald G. Johnson, M.D., New York, Professor of Obstetrics and Gynecology, Cornell University—"Obstetric Hemorrhage."

5:00—Adjourn.

5:45—Exhibits Close for the Day.

EVENING

No events will be scheduled by the Rocky Mountain Medical Conference for this evening, which is left open for meetings of alumni, specialties, or fraternal groups as desired.

THURSDAY, MAY 10

MORNING

8:00—Registration and Exhibits Open.

Clyde H. Frederickson, M.D., Missoula, President, Montana Medcal Association, Presiding.

8:30-10:30—Full-color Television, Surgical Clinics.

10:30-11:00—Intermission.

11:00-11:30—Martin T. Van Studdiford, M.D., New Orleans, Professor of Dermatology, Tulane University—"Malocclusion: Its Relationship to Lip and Buccal Membrance Disorders."

11:30-12:00—Frank P. Foster, M.D., Boston, Chief of Medical Service, Lahey Clinic—"Simple Classification and Management of Functional Menstrual Disorders."

12:00—Recess.

AFTERNOON

Leland S. Evans, M.D., Las Cruces, President, New Mexico Medical Society, Presiding.

1:00-3:00—Full-color Television: Medical Clinics.

3:00-3:30—Intermission.

3:30-4:15—J. Vernon Luck, M.D., Los Angeles, Orthopedic Surgeon—"The Anatomical Interpretation of the Arthritides as a Basis for the Diagnosis and Therapy."

4:15-5:00—George M. Curtis, M.D., Columbus, Professor of Surgery, Ohio State University—"Current Management of Thyroid Disease."

5:00—Adjourn.

5:45—Exhibits Close for the Day.

EVENING

7:00—Banquet for the doctors and their wives in the Lincoln Room of the Shirley-Savoy Hotel.

9:00-12:00—Dancing.

FRIDAY, MAY 11

MORNING

8:00—Registration and Exhibits Open.
V. P. White, M.D., Salt Lake City, President, Utah State Medical Association, Presiding.

8:30-10:30—Full-color Television, Surgical Clinics.

10:30-11:00—Intermission.

11:00-11:30—Donald G. Johnson, M.D., New York, Professor of Obstetrics and Gynecology, Cornell University—"The Elderly Primipara."

11:30-12:00—George M. Curtis, M.D., Columbus, Professor of Surgery, Ohio State University—"The Recognition and Management of Splenic Disease."

12:00—Recess.

AFTERNOON

Karl E. Krueger, M.D., Rock Springs, President, Wyoming State Medical Society, Presiding

1:00-3:00—Full-color Television: Medical Clinics.

3:00-3:30—Intermission.

3:30-4:15—Frank P. Foster, M.D., Boston, Chief of Medical Service, Lahey Clinic—"Practical Considerations in the Use of Antibiotics."

4:15-5:15—Louis A. Buie, M.D., Rochester, Chief of Proctology, Mayo Clinic—"Proctology From the Standpoint of the General Practitioner, the Internist and the Surgeon."

5:15—Adjourn.

TENTATIVE SCHEDULE FOR TELEVISION CLINICS

WEDNESDAY, MAY 9

MORNING

8:30—Opening Remarks and Welcome.—Ervin A. Hinds, M.D., President, Colorado State Medical Society.

8:35 to 10:30—Surgical Operative Clinics. Gastric Resection; Herniorrhaphy; Maxillo-facial Surgery; Hare Lip. Details to be announced in final Television Program.

AFTERNOON

1:00-2:00—Seminar on Poliomyelitis.

2:00-2:20—Incidence of Rheumatic Fever.

2:20-2:40—Ophthalmoscopic Findings in Systemic Diseases.

2:40-3:00—Preoperative Case Conference (one of the cases to be operated upon in the televised surgical clinics the following morning).

THURSDAY, MAY 10

MORNING

8:30 to 10:30—Surgical Operative Clinics. Mitral Valvulotomy or Patent Ductus Arteriosus; Thyroidectomy; Perineorhaphy or Hysterectomy; Colectomy. Details to be announced in final Television Program.

AFTERNOON

1:00-1:20—Rehabilitation; Orthopedic Cases, Fitzsimons General Hospital.

1:20-1:40—Rehabilitation; Chest Cases, Fitzsimons General Hospital.

1:40-2:00—Experience With ACTH in Rheumatic Fever.

2:00-2:25—Gastroscopy: Its role in Clinical Medicine.

2:25-2:50—Preoperative Case Conference (one of the cases to be operated upon in the televised surgical clinics the following morning).

FRIDAY, MAY 11

MORNING

8:30 to 10:30—Surgical Operative Clinics. Open Reduction of Fractures; Hemorrhoidectomy; Cholecystectomy; Thoracotomy. Details to be announced in final Television Program.

AFTERNOON

1:00-1:35—Surgical Treatment of Mitral Stenosis.

1:30-1:55—Medical Management of Thyrotoxicosis.

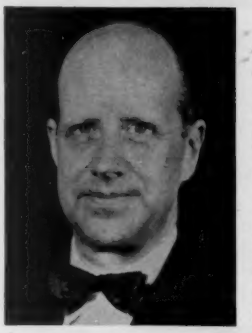
1:55-2:15—Use of Radioactive Iodine in Thyroid Diseases. Demonstration.

2:15-2:25—Use of Cortisone in Boeck's Sarcoid. Case Presentation.

2:25-2:55—X-ray Diagnostic Conference. (Cases from Teaching Files at Denver General Hospital and Fitzsimons General Hospital.)

Guest Speakers

M. T. Van Studdiford, M.D., New Orleans, Louisiana; Clinical Professor of Skin Diseases at Tulane University School of Medicine. Consultant in Dermatology, U. S. Marine Hospital, New Orleans, and U. S. Marine Hospital for Leprosy, at Carville, Louisiana. Chief of Staff, Department of Dermatology, Charity Hospital, New Orleans, Louisiana.



Frank P. Foster, M.D., Boston; Chief of a Medical Service, Lahey Clinic. Member of American Board of Internal Medicine; Fellow, American College of Physicians; American Medical Association; New England Rheumatism Association, and American Rheumatism Association. Vice President of the American Heart Association.

J. Vernon Luck, M.D., Los Angeles, California; Assistant Clinical Professor of Orthopedic Surgery, University of Southern California. Senior Attending Physician, Department of Orthopedic Surgery, and Consultant in Orthopedic Pathology, Los Angeles County Hospital. Member, Board of Associate Editors, Journal of Bone and Joint Surgery. Author of textbook entitled, Bone and Joint Diseases.

Donald G. Johnson, M.D., New York; Professor of Obstetrics and Gynecology, Cornell University Medical College, and Associate Attending Obstetrician and Gynecologist to the New York Hospital (New York Lying-In Hospital). Member, New York Obstetrical Society, Harvey Society of New York, County and State Medical Societies and Fellow, A.M.A.

Louis A. Buie, M.D., Rochester, Minnesota; Chief of the Department of Proctology of the Mayo Clinic; Professor of Surgery (Proctology), Mayo Foundation, University of Minnesota, Rochester, Minnesota. Member of the Judicial Council of the American Medical Association. Secretary of the American Board of Proctology.

George M. Curtis, M.D., Columbus, Ohio; Professor of Surgery, Ohio State University. Member of the American Surgical Association, the American Society for Clinical Investigation, the American Association for the History of Medicine, the American Association of Anatomists, the American Physiological Society and the American Society for Experimental Pathology. One of the active founders of the Central Surgical Association and served in 1940 as its secretary and in 1946 as its president.

GUEST SPEAKERS (Continued)

John A. Anderson, M.D., San Francisco, California; Professor of Pediatrics, Stanford University of Medicine. Member of the following Medical and Scientific Societies: Society of Experimental Biology and Medicine, Society of Pediatric Research, Association for the Study of Internal Secretions, American Federation Clinical Research, American Public Health Society (Fellow), American Academy of Pediatrics, Western Clinical Research Society, American Pediatric Society and the Utah Public Health Association, and others

THE R.M.M.C. RUNS BY THE CLOCK!

The Scientific Programs of the Rocky Mountain Medical Conference are run by the clock, to the minute. This has been true of the five previous meetings, and it will be true this May.

All meetings will begin on time, all speakers will be required to begin their presentations exactly on time and none will be permitted to speak longer than as scheduled in the program. All who attend the Conference are requested to assist the speakers and benefit themselves by being in the meeting room a few minutes in advance of the papers they wish to hear. Any member who arrives late to hear any particular paper is assured that he will miss part of that paper! Also, his late arrival would be disturbing to the speaker and to the audience alike.

HOTEL RESERVATIONS

All major downtown hotels in Denver have set aside blocks of rooms to accommodate doctors and their families attending the Rocky Mountain Medical Conference. Reservations for the Conference will be handled through a Housing Committee of Denver physicians assisted by the Denver Convention and Visitors Bureau.

All members in the five-state area will soon receive a letter enclosing a hotel reservation blank giving full details of hotel rates. It is requested that this blank be used if possible. Any who mislay the reservation form may write direct to Housing Committee, Rocky Mountain Medical Conference, 225 West Colfax Avenue, Denver, Colorado.

POCKET PROGRAM

A final program for the Sixth Rocky Mountain Medical Conference, complete with additional details not available for the Program Number of the Journal, will be published in pocket size in April and mailed to all members of the participating State Medical Societies.

ENTERTAINMENT

As the tentative program shows, there will be a stag smoker and entertainment the evening of Tuesday, May 8, this being actually the evening before the opening of the Conference. This evening was chosen for the stag party since most doctors will arrive in Denver that day in order to be on hand for the opening of the television surgical clinics the next morning; also so that Wednesday evening may be free for other meetings not connected with the Conference.

The Woman's Auxiliary of the Colorado State Medical Society and the Auxiliary of the Denver Medical Society will provide special entertainment for ladies who accompany their doctor husbands at this Conference. Details will be announced in the final program to be mailed in mid-April.

Banquet and Dance

Doctors and their ladies will join in one major entertainment function Thursday evening, May 10. On that evening the Lincoln Room of the Shirley-Savoy will be the scene of an outstanding banquet entertainment and dance. There will be no speaker at this banquet, rather there will be entertainment of a type so that everyone will remember this as an evening of relaxation and fun. After the entertainment, one of Denver's best dance orchestras will provide music for those who wish to trip the light fantastic, and those who prefer a quiet card game with their favorite bridge partner will find that their part of the party is also well organized.

Banquet tickets will be available at the Conference Registration desk and should be purchased, if possible, at least twenty-four hours in advance since there is a possibility that the supply will have to be limited.

PARTIAL LIST OF SCIENTIFIC EXHIBITS

Malignant Melanoma—Dr. William Coppinger, Dr. Arthur Woodburne and Dr. Kenneth C. Sawyer.

The Medical Aspects of Acute Radiation Injuries —Los Alamos Medical Center, Los Alamos, New Mexico (Dr. Loren F. Blaney).

Cancer of the Skin—Dr. Douglas W. Macomber.

Intrathoracic Goiter—Dr. Chauncey A. Hager.

(Movies) (1) Removal of a Massive Osteoma of the Skull and Tantalum Cranioplasty, (2) Subdural Hematoma in Infants, and (3) Psychosurgery—Dr. Ralph M. Stuck.

Parotid Tumors—Dr. Mason Morfit.

Interauricular Septal Defects, Storage of Arterial Homografts, Pathologic Study of the Survival of Arterial Homografts After Transplantation, and (Movie) Method Used in Inserting an Arterial Homograft in the Dog—Department of Surgery, University of Colorado School of Medicine.

Bronchographic Study Relative to the Development of a New Media for Bronchography—Department of Surgery, University of Colorado School of Medicine.

The Electroencephalograms of Children—Department of Psychiatry, University of Colorado School of Medicine (Dr. Ewald W. Busse, Dr. Edward G. Billings, Dr. Harold D. Palmer and Dr. Bryce G. Hughett).

The Walking Blood Bank Program—The Belle Bonfils Memorial Blood Bank (Dr. Marion R. Rymer).

Plastic and Reconstructive Surgery—Dr. A. W. Mayer, Jr.

Tumors Induced by Nerve Section in an Insect —Department of Anatomy, University of Colorado School of Medicine (Dr. Berta Scharrer).

Blood Supply of the Brain—Department of Anatomy, University of Colorado School of Medicine (Dr. Ernst Scharrer).

Peptic Ulcer of the Normally Shaped Duodenal Bulb—Dr. Mark S. Donovan.

Dental Prosthesis—Hobart H. Proctor, D.D.S.

Oral and Facial Injuries and Deformities—Dr. Guy W. Smith.

The Prematurity Problem—The Premature Infant Center, Colorado General Hospital and the Colorado State Department of Public Health.

Laboratory Services Essential to Public Health —The Colorado State Department of Public Health.

TECHNICAL EXHIBITS

Abbott Laboratories

Aloe, A. S., Company.

Ames Company, Inc.

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M & R Dietetic Laboratories, Inc.

Mead Johnson & Company.

Mosby, C. V., Company.

Muckle X-Ray Company.

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Ortho Pharmaceutical Corp.

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Pfizer, Chas., and Co., Inc.

Philip Morris & Company, Ltd., Inc.

Physicians & Surgeons Supply Co.

Robins, A. H., Company, Inc.

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ROCKY MOUNTAIN MEDICAL CONFERENCE

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Commercial Exhibits: Harvey T. Sethman, Denver; W. Howard Tibbals, Salt Lake City; L. Russell Hegland, Billings; Ralph W. Marshall, Albuquerque; Arthur R. Abbey, Cheyenne.

Television Committee: William B. Condon, Reginald Fitz, David H. Watkins.

Case Report—

(Continued From Page 270)

urethral recovery of the foreign body is usually resorted to in cases where the object is accessible to cystoscopic manipulation and removal possible without causing undue trauma to bladder or urethra. Calcification about the object may be fragmented with the lithotrite, the fragments removed, and subsequently followed by removal of the foreign body. In cases of long standing, however, where the bladder capacity is reduced by inflammation and contraction of the bladder wall and where the foreign body is imbedded in the mucosa, transvesical manipulation may prove surgically to be the safer method. In any event, perforation of bladder and trauma to urethra must be guarded against and the transvesical method utilized whenever possibility of damaging sequelae resulting from transurethral manipulation exists.

CASE REPORT

D. R. B., a female child of four, was admitted to the hospital on January 26, 1948, with the complaint of enuresis for six weeks, associated with bloody secretion on bedding and wearing apparel. The age of the child precluded the procurement of reliable history. The child had no complaints of pain or urinary disturbances other than related by her mother. Along with enuresis there was dysuria and increasing urinary frequency, first observed two months prior to admission. Information pertaining to insertion of the foreign body was unobtainable.

Physical examination revealed a well-developed and mentally alert child of stated age, with no complaints. Some slight discomfort was elicited on deep palpation over the suprapubic area. The kidneys were not palpable and there was no costovertebral tenderness. The skin about the genitalia and buttocks was inflamed, dry, and moderately excoriated. The external urethral meatus was edematous and puckered. There was no vaginal discharge. Rectal temperature was 100, pulse 116, blood pressure 103/70, and respiration 28. General physical examination otherwise negative.

Laboratory findings: Erythrocytes 3,670,000; hemoglobin 76 per cent; leukocytes 5,600 with a normal differential count. Voided urine—alkaline, sanguino-purulent, specific gravity 1:016; albumin 2 plus; no casts; numerous wbc and rbc and triple phosphate crystals. Catheterized specimen presented approximately the same findings. During catheterization, a grating sensation was transmitted to the fingers as the catheter entered the bladder. This observation and elicited suprapubic tenderness led to suspicion of foreign body in the bladder. The suspicion was promptly confirmed by a roentgenogram (Fig. 1). That the encrusted bobby pin was fixed in position was verified by the observation that the calculus did not change its position with relation to changing position of the patient.

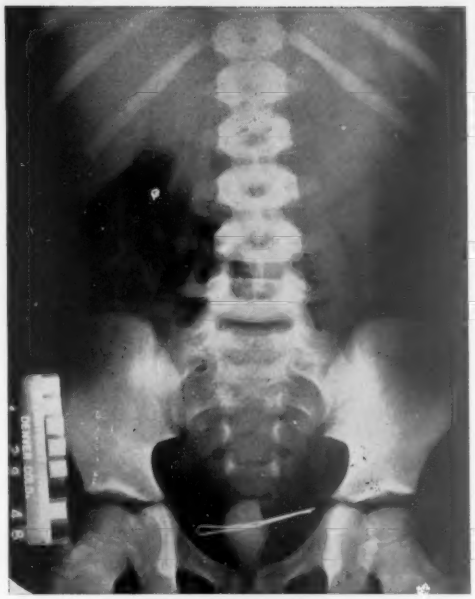

Fig. 1. A-P Flat Plate.

Transvesical approach for removal of foreign body was decided on because of the fixed transverse position of the bobby pin and age of the patient, whose small urethral lumen precluded use of instrumental manipulation.

Preparatory to surgery, the child was placed on a regime of hydration, antibiotics, rest, and supportive treatment. Within a few days the temperature stabilized at a normal level and surgery was performed on February 2, 1948.

Operative technic: The bladder was approached through the classical longitudinal suprapubic incision. The perivesical structures were fibrous and adherent to the viscus. Blunt and sharp dissection was used to free the bladder from the peritoneum and its enveloping fascia. Upon incising the bladder it was observed that the bladder wall was thickened and mucosa diffusely inflamed. The bobby pin lay transversely in the bladder with its ends buried in the mucosa. A phosphatic calcification the size of a walnut was suspended on the bobby pin over and proximal to the trigone. The serosa was not perforated. The encrusted pin (Fig. 2) was removed and the bladder closed around a Pezzar catheter with double O chromic catgut. Two penrose drains were placed along either side of the bladder and the incision approximated in layers, using interrupted sutures. A No. 14F Foley catheter was inserted into the bladder per urethram.

Postoperative course: Convalescence was without incident. The postoperative temperature reached 103.4 (rectally) first day, leveling to normal on the fifth day.

The penrose drains were removed within 48 hours and the Pezzar catheter on the fourth day, leaving the urethral retained catheter in to the ninth day, when the suprapubic sinus was closed. Despite infection prevalent in and about the bladder, the incision healed by primary intention. The patient was discharged on the eleventh postoperative day with freedom from enuresis, dysuria, and a grossly clear urine. Albuminuria, pre-operatively observed, disap-

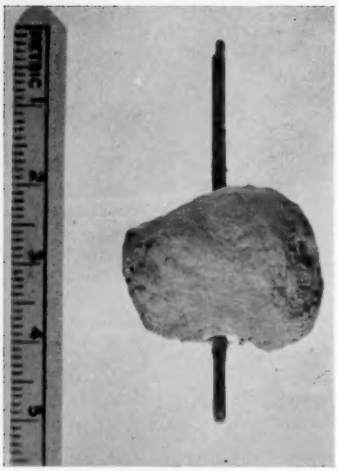

Fig. 2. Gross Specimen.

peared before dismissal and a negative urine was obtained within four weeks after surgery. Obviously albuminuria was not due to involvement of renal parenchyma but to by-products in the urine incidental to diffuse cystitis.

Discussion

This child did not report inserting a bobby pin into her bladder and her inherent stoicism prevented complaints. The deviations from normal, as observed by the mother, were return of enuresis, from which the child was free for two years, and blood stained spots on the bedding and night clothes. No complaints were registered by the child, a phenomenon difficult to explain. Several physicians were consulted and various diagnoses advanced, such as tonsillitis, nephritis, vaginitis, neurosis, etc. Accordingly, therapeutics recommended included tonsillectomy, chemotherapy, antibiotics, diet, and sedatives. Results were, as one would expect, quite unsatisfactory.

This case report re-emphasizes the plea of urologists that any case with persistent pyuria or hematuria deserves diagnosis before antibiotics or chemotherapy is prescribed. An accurate urological evaluation of signs and symptoms is no longer the bugbear that it was in yester days. One cannot over-emphasize the importance of determining the specific source of the pyuria or hematuria, be it the urethra, bladder, or the upper urinary tract. Subsequent management of the case will necessarily depend upon establishment of this fact.

Catheterizing the patient, the simplest of all urological procedures, afforded us the diagnostic clue. The grating sensation transmitted by the intra-vesical portion of the catheter led to suspicion of foreign body which was confirmed by the roentgenologist. Cystoscopy was considered unnecessary and surgical removal of the foreign body decided upon.

The transvesical approach was selected because the heavily encrusted bobby pin was observed lying transversely in a bladder of small capacity with its ends imbedded in the mucosa. The small caliber of the urethra precluded insertion of lithotrite without causing serious damage to the delicate mucosa and muscle fibers which, in the female, constitute the urethral sphincter. Freeing of the pin through the cystoscope would have proved technically difficult, if at all possible, and perforation of the bladder not unlikely. It is perhaps this fixed position of the foreign body, which was virtually suspended above and beyond the trigone, that accounts for few and insignificant subjective symptoms. Urinations, while frequent, were at no time associated with urgency and terminal pain.

That the proof of the pudding is not in the eating alone, but rather in its digestion, is borne out by the fact that the child made an uneventful recovery, the enuresis disappeared, and her urine was normal within one month following surgery, and remained so to date.

Conclusions

1. An unusual case of foreign body in the bladder of a child is reported.

2. The presence of pyuria or hematuria make urological investigation mandatory.

3. The methods of treatment are discussed and the transvesical approach in this case justified.

4. The establishment of a diagnosis should precede, rather than follow, the use of chemotherapy or antibiotics.

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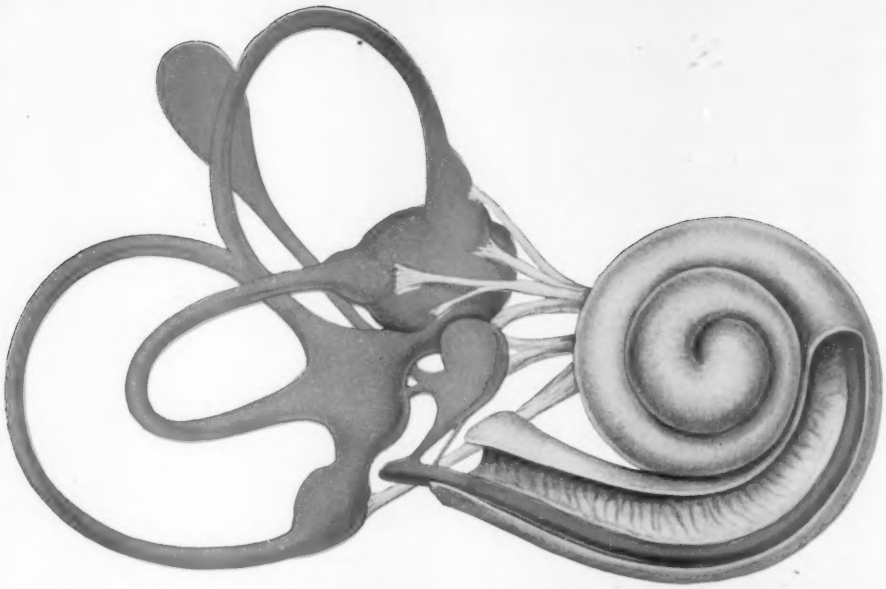

Detail of the Labyrinthine Structure

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—Tuttle, A. D.: Special Breakdown of Case Histories, presented at the Airlines Medical Directors Association Meeting, New York, N. Y., Aug. 28, 1949.

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NEW MEXICO Medical Society

SIXTY-NINTH ANNUAL SESSION NEW MEXICO MEDICAL SOCIETY

May 3, 4, 5, 1951
Santa Fe

PRELIMINARY PROGRAM

(Detailed programs will be mailed soon to all Physicians in the Rocky Mountain Area)

THURSDAY, MAY 3

The House of Delegates will meet all morning, and will reconvene at later times during the three-day convention as needed.

The New Mexico Academy of General Practice will hold its annual meeting at luncheon Thursday, May 3, at La Posada Inn.

Scientific sessions of the New Mexico Medical Society begin at 1:00 p.m. Thursday, and will continue with morning and afternoon sessions through Saturday afternoon.

A smoker for all attending physicians will be held Thursday evening, May 3.

FRIDAY, MAY 4

Scientific Sessions will be held morning and afternoon, with a Round Table Luncheon Discussion over the noon hour. Featured will be a symposium on Medical Aspects of the Atomic Bomb, and Radiation Injuries.

The Annual Banquet and Dance for all doctors and their wives will be held this evening, Friday May 4.

SATURDAY, MAY 5

This will be known as "Cardiac Day." The entire morning and afternoon scientific programs, and the noon-time luncheon discussion, will be devoted to symposia on modern medical, surgical, and radiological aspects of cardiac diseases, acquired and congenital.

GUEST SPEAKERS

The list of speakers is not final in time for this preliminary program, the committee not having had final confirmation from several who plan to take part. Included among the guest speakers whose appearance is confirmed are:

Owen H. Wangensteen, M.D., Professor of Surgery, University of Minnesota.

George C. Griffith, M.D., Professor of Medicine, University of Southern California, and two of his associates from the departments of Radiology and Surgery, to take part in the "Cardiac Day."

Marcy Sussman, M.D., Clinical Professor of Radiology, University of Southern California.

Howard B. Sprague, M.D., Boston, Harvard Medical School, President of the American Heart Association.

William Oakes, M.D., and members of his staff, from the Los Alamos Medical Center, Los Alamos, N. M.

TRUDEAU SOCIETY

The New Mexico Trudeau Society will hold its annual meeting at a luncheon at La Posada Inn, Friday, May 4, in connection with the New Mexico Medical Society's Annual Session.

WOMAN'S AUXILIARY

The complete program for the Woman's Auxiliary to the New Mexico Medical Society follows:

Thursday, May 3

10:00 A.M. Registration desk opens in La Fonda Lobby.

2:00 P.M. *Special Meeting and Tea for members of the Woman's Auxiliary to the State Medical Society at the home of Mrs. H. D. Corbusier, Old Pecos Trail.

7:00 P.M. Cocktail Buffet for wives of all visiting doctors at the home of Dr. and Mrs. H. S. A. Alexander as guests of the wives of the members of the Santa Fe County Medical Society.

Friday, May 4

10:00 A.M. *Annual Meeting, Woman's Auxiliary to the New Mexico State Medical Society, for members only, Arrowhead Lodge, Glorietta.

12:30 P.M. *Luncheon for wives of all visiting doctors at Arrowhead Lodge as guests of the wives of the members of the Santa Fe County Medical Society.

7:00 P.M. Banquet for doctors and wives at La Fonda.

*Transportation to these events will be provided on application to the Registration Desk at La Fonda.

UTAH
State Medical Association

REPORT OF THE AUXILIARY TO UTAH STATE MEDICAL ASSOCIATION

A very interesting meeting of the board of the Auxiliary to the Utah State Medical Association was held in the state medical offices January 16, with Dr. L. J. Paul as the principal speaker. His subject was "Civilian Defense," and he urged all Auxiliary members to become familiar with the program of both the state and the national. A plan for civilian defense against air attack was begun last summer, and was patterned after the British plan of small groups, as they found dictatorship of the masses soon collapsed. Schools were conducted to train the heads of these defense units. Cities were to be organized as a unit, where hospitals will give 24-hour service, doctors are assigned to stations in case of emergency, drug stores and pharmacies are to be ready with ready-packaged supplies, while lay people are asked to have emergency bundles of bandages, narcotics, etc. The highway patrol will take all cases to the various schools, and not to the hospitals. The Red Cross will furnish blood, etc. Dr. Paul said that coast cities would be in charge of the military, but the state of Utah will be under deputies. Refresher courses should be taken by all women, and as many of the men as possible.

In addition to Dr. Paul's talk, reports of the various county presidents and committee chairmen were given. Weber County gave a large dessert-bridge party in December to raise funds for the student nurse scholarship. On February 5, at the regular monthly meeting, Mrs. Rulon F. Howe, President of the Weber Auxiliary, presented to Sister M. Berno, director of nurses at St. Benedict's Hospital, a check for $75 for a nurse scholarship, while a similar amount was presented to Mrs. M. J. Seidner, director of nurses at the Dee Memorial Hospital.

Central Auxiliary had a joint dinner meeting with the doctors, after which they adjourned to the home of Mrs. Noyes for a business meeting and to hear the message of the State President, Mrs. Orin A. Ogilvie. Mrs. Ogilvie stressed the need for forming study groups in medical education, among these the twelve point program of the A.M.A., the School Health program, the operation of the Blue Shield and the Blue Cross, the state's program of First Aid and Civilian Defense.

Carbon County reported that they had followed the State Auxiliary program in every respect, as well as entertaining the doctors in this area at a dinner-dance.

Utah County had the pleasure of hearing Dr. H. C. Branch of the University of Utah Medical School faculty at their February 5 meeting, while at the March meeting five professors from the medical school gave a Symposium on Cancer. The state officers were also guests. Utah County Auxiliary had its annual rummage sale, which netted them $288. Of this sum $50 was given to the Heart Clinic at the Utah Valley Hospital, while the remainder was used for two nurse scholarships in the same hospital.

Salt Lake County reported a dinner-dance given on the 24th of February on the roof of the Hotel Utah. Interns and residents were special guests. The proceeds from this dance will be used to finance some of the special charities in Salt Lake County. Mrs. C. O'Neal Rich, President of Salt Lake County Auxiliary, reports that sixty members had signed up for First Aid and Civil Defense Courses.

Cache County honored Mrs. Ogilvie and the state officers at a dinner meeting on March 5.

Reports from committee chairmen were most interesting and worth while, and it would seem that all Auxiliary members are awake to the need of service in the state. This whole-hearted endeavor is indeed paying big dividends in Utah.

MRS. CLAUDE L. SHIELDS,
Chairman of Press Publicity.

COLORADO
State Medical Society

Component Societies

NORTHEAST COLORADO MEDICAL SOCIETY

At the regular meeting of the Northeast Colorado Medical Society on February 8, Dr. Carl Josephson of Denver spoke on "Coronary Disease, Its Diagnosis and Treatment." Dinner was sponsored by the Auxiliary and served at the Country Club in Sterling. This was one of the most practical meetings the society has had.

KENNETH H. BEEBE, M.D., Secretary.

AMERICAN GOITER ASSOCIATION

The 1951 meeting of the American Goiter Association will be held in the Deshler-Wallick Hotel, Columbus, Ohio, May 24, 25 and 26, 1951.

The program for the three-day meeting will consist of papers dealing with goiter and other diseases of the thyroid gland, dry clinics and demonstrations.

Denver Forms Fund Committee

The Denver Medical Society has created a Medical Education Fund Committee to actively sponsor and promote the American Medical Education Foundation, launched a few months ago by the A.M.A. to help relieve medical schools which are in financial difficulties.

The following report, submitted by a preliminary study committee chairmanned by Dr. J. Lawrence Campbell, was adopted by the Council of Delegates of the Denver Medical Society on March 14, and is published for the information of all other members in Colorado who may be interested in forming similar committees:

The Medical Education Fund Committee believes the following factors are to be considered in relation to the problem:

1. Medical schools are in financial distress due to:

a. Inflationary conditions on a national basis.

b. Inability to obtain funds from the usual source of voluntary and endowment sources.

c. Medical and scientific advancement of highly technical nature which in themselves increase operative costs.

(Continued on Page 288)

INFECTIONS OF THE URINARY TRACT

Results of therapy in 32 obstetrical and gynecological cases

	ORGANISM	NO. OF CASES	RESULTS		
			GOOD*	EQUIVOCAL	POOR
No organic or obstructive disease					
	B. coli	15	14	1	0
	A. aerogenes	4	4	0	0
	Aerobic diphtheroids	3	2	1	0
	S. albus	2	2	0	0
	Aerobic non-hemolytic streptococcus	2	2	0	0
	Ps. aeruginosa	1	0	1	0
With organic or obstructive disease					
	Ps. aeruginosa	3	1	0	2
	P. vulgaris	1	0	1	0
	A. aerogenes	1	1	0	0
	TOTALS	**32**	**26**	**4**	**2**

Douglas, R. G.; Ball, T. L., and Davis, I. F.: California Med. 73:463 (Dec.) 1950

*"*A good result was recorded when in 72 hours or less the temperature fell to normal, the pyuria cleared, a negative culture was obtained and the patient was symptom-free."*

CRYSTALLINE

Terra

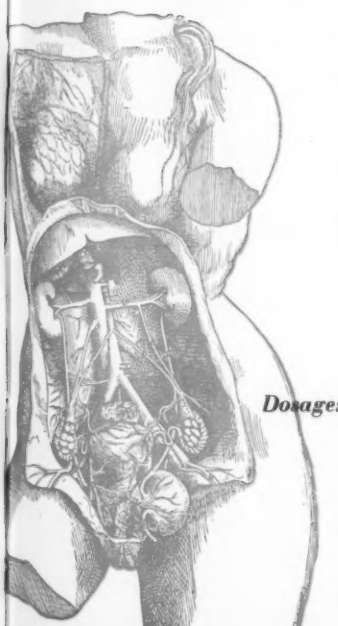
"The drug is tolerated by mouth and no serious side-reactions occur."

Douglas, R. G.; Ball, T. L., and Davis, I. F.: California Med. 73:463 (Dec.) 1950.

Antibiotic Divisio

OBSTETRICAL AND GYNECOLOGICAL PATIENTS

"prompt and effective" response



"In cases in which there is no organic or obstructive disease, the response to Terramycin as a urinary antiseptic is prompt and effective."

"The patients with pyelitis of pregnancy or simple postoperative cysto-ureteritis responded very promptly....There was a prompt drop in temperature, disappearance of pyuria and bacilluria, and symptomatic relief."

Douglas, R. G.; Ball, T. L., and Davis, I. F.: California Med. *73*:463 (Dec.) 1950.

Dosage: 2 Gm. daily by mouth in divided doses q. 6 h. is suggested for most acute infections. In severe infections, a high initial dose (1.0 Gm.) or higher daily dosages (3 to 6 Gm.) should be used. Treatment should be continued for at least 48 hours after the patient's temperature has become normal and acute symptoms have subsided.

amycin

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100 mg. capsules, bottles of 25 and 100;
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Organization

(Continued From Page 284)

d. Demands for increasing enrollment.

e. Demands for training of graduate students in medicine and allied fields.

2. At the present time legislation is pending in Congress for Federal Subsidy for Medical Education both in direct help for medical tuition and in addition for expansion of student enrollment and existing facilities.

a. Above fostered by Association of Medical Colleges, Association of Deans of Medical Colleges, Public Health Service, American Dental Association, American Legion, Federal Security Administration, and others too numerous to mention.

3. The contribution of a substantial amount of money to the cause of medical education by the American Medical Association, through its component societies, will greatly improve public relations and serve as a stimulus for contribution by industry and other private sources.

a. It must be understood that this donation must be on an annual basis for the next several years or until a change in policy is effected.

b. The American Medical Association has set up a foundation for this purpose to be operated without overhead costs. It is the duty of component societies to support this national program.

c. The donation of funds to the American Medical Association Foundation may be earmarked for a particular medical school if the donor chooses.

After reviewing the problem in the light of the previously mentioned facts your committee wishes to submit the following resolution:

Resolved, That the Medical Society of the City and County of Denver establish a local committee to secure voluntary contributions to the Foundation from its members. It is suggested by the American Medical Association that each physician consider an annual contribution of $100.00. A physician who finds such a contribution beyond his means should be urged to demonstrate his support of the Foundation by a contribution of a smaller amount.

Following adoption of the above report as submitted by Dr. Campbell's committee, the Denver Council directed the President of the Society, Dr. Edgar Durbin, to appoint a special committee to proceed with solicitation and collections for the fund. The new committee is composed of Drs. Atha Thomas, Chairman; J. Lawrence Campbell, Byron I. Dumm, George Postma, Eugene S. Auer, Herman I. Laff, Joseph D. Friedland, Isadore Gersh, Robert M. Burlingame, Gunnar Geistrup, E. G. Billings, Joseph H. Lyday, George D. Ellis, Fred R. Calhoun, Sidney E. Blandford, Jr., E. Stewart Taylor, W. A. H. Rettberg, McDonald Wood, and Warren Tucker.

PAPERS AND EXHIBITS INVITED FOR STATE MEETING

Members of the Colorado State Medical Society who desire to offer scientific papers or scientific exhibits for the Annual Session to be held next September should get in touch immediately with Dr. Kenneth C. Sawyer, 1820 Gilpin Street, Denver, Chairman of the Committee on Scientific Work.

Dr. Sawyer announces that there are still a number of places available on the program for papers, whether or not illustrated with slides or movies, which will interest general practitioners and the broader specialties. Also, it is planned this year to feature a larger number of scientific exhibits than were shown in 1950, when exhibit space was at a premium.

Members of the Society are cautioned that the By-Laws limit Annual Session presentations to fifteen minutes, except for those given by guest speakers.

COLORADO
Medical School Notes

NEW COURSE AT GREELEY

Doctors in northeastern Colorado and nearby areas of Wyoming and Nebraska will have a unique opportunity to attend a series of postgraduate activities given every Thursday evening for six consecutive weeks.

This program will offer the busy practitioner a review of recent advances in surgery, medicine and obstetrics with minimal loss of time from his practice.

The Weld County Hospital in Greeley, Colorado, is centrally located and easily accessible to the doctors in northeastern Colorado and to the physicians immediately adjoining. This is the first time that the faculty of the University of Colorado School of Medicine has participated in a series of weekly evening conferences for the practicing physician of Colorado in the physican's own area.

Twelve one-hour conferences by capable teachers have been arranged, April 19 through May 26, 1951; Thursday evening from 7:30 p.m. to 9:30 p.m. This series of teaching conferences for general practitioners will be held at the Weld County Hospital, 16th Street and 11th Avenue, Greeley, Colorado.

The Weld County Medical Society, assisted by the Educational Committee on Medical Education of the Colorado State Medical Society and the University of Colorado's Office of Graduate and Postgraduate Medical Education, are sponsoring this series of lectures. This is a new departure aimed to bring refresher courses to or near the doctor's home town. The teachers selected to put on this program are practitioners of medicine who are well qualified to present the recent advances in their field.

Financial arrangements and enrollment will be managed by the Office of Graduate and Postgraduate Medical Education at the Medical School. The tuition will be $15.00, and checks should be made payable to the University of Colorado and mailed to the Director of Graduate and Postgraduate Medical Education, 4200 East Ninth Avenue, Denver, Colorado.

This course of instruction will be approved for twelve hours of credit by the Colorado Chapter of the American Academy of General Practice.

Courses similar to this can be arranged by any hospital or county society by contacting the Committee on Medical Education of the State Medical Society or the Office of Graduate and Postgraduate Medical Education of the University of Colorado School of Medicine.

Alumni Seniors, Interns and Residents of the University of Colorado School of Medicine will be able to compare notes at the annual Senior, Alumni and Intern-Resident Graduate Week, which will be held at the school from June 1 to June 9. In announcing the schedule, Dr. Charley J. Smyth, Director of Graduate and Postgraduate Medical Education, said the week-long program has been instigated for the first time so that Alumni, Seniors, Interns and Residents may have a look at what the other has been doing. Prior to this year, separate pro-

"Nowhere in medicine are more dramatic therapeutic effects obtained than those which follow estrogen therapy in the girl who has failed to develop sexually. A daily dose of 2.5 to 3.75 mg. of 'Premarin' given in a cyclic fashion for several months may bring about striking adolescent changes in these individuals."*

* Hamblen, E. C.: Some Aspects of Sex Endocrinology in General Practice, North Carolina M. J. 7:533 (Oct.) 1946.

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Estrogenic Substances (water-soluble) also known as Conjugated Estrogens (equine).

"Premarin"—a naturally occurring conjugated estrogen—long a choice of physicians treating the climacteric—has been earning further clinical acclaim as replacement therapy in hypogenitalism.

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Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg., and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

"Premarin" contains estrone sulfate plus the sulfates of equilin, equilenin, β-estradiol and β-dihydroequilenin. Other α- and β-estrogenic "diols" are also present in varying amounts as water-soluble conjugates.

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grams were held for each group. Another new feature of this year's plan is the inclusion of a special Alumni Scientific Program, during which a number of well-known alumni will present highlights of their own research. Dr. Robert M. Zollinger, professor and chairman of the Department of Surgery at Ohio State University, Columbus, will speak at the Denison Auditorium Tuesday night, June 5. Dr. Zollinger also will participate in the two clinic days, to be held Monday, June 4, and Tuesday, June 5.

Alumni have been advised of preliminary plans in a letter from Dr. Thad Sears, president of the Medical School Alumni Association of the university. The tentative schedule of events is as follows:

Friday, June 1—Morning, Alumni Scientific Program.

Saturday, June 2—Morning, Alumni Scientific Program; afternoon, Senior-Alumni ball game and ladies' social function; evening, Alumni banquet.

Sunday, June 3—Evening, Baccalaureate, President and Dean's reception.

Monday, June 4—Morning and afternoon, Colorado Intern and Resident Clinic Day; evening, formal talk.

Tuesday, June 5—Morning and afternoon, Colorado Intern and Resident Clinic Day; evening, Senior-Faculty dinner.

Wednesday, June 6—Senior picnic.

Thursday, June 7—Evening, Senior formal dinner-dance.

Saturday, June 9—Morning, Commencement.

All events except the commencement will be held in Denver.

FROM BRANCH OF STUDENT A.M.A.

Students of the University of Colorado School of Medicine have formed the "Colorado Academic Society of the Student American Medical Association." Although Colorado students were not represented at the first meeting of the Student American Medical Association held in Chicago, December 28 and 29, 1950, the Colorado Academic Society was organized late in February and Colorado thereby became a charter member of the Student A.M.A. Provisions of the original constitution adopted by representatives of forty-seven medical schools December 29 provided that other academic societies which ratified the proposed national constitution before March 1 should become charter members.

Thomas W. Moore, a Junior student at the University of Colorado School of Medicine, is president of the new Colorado Academic Society. A constitution and by-laws for the local organization will be drafted within the next month by a committee composed of the following students: Roger F. Eakins, Secretary of the Society; Millard J. Smith, Robert N. Humphrey and Marshall J. Hannum.

Nationally, the Student A.M.A. plans to hold annual meetings, probably in December, in order to take advantage of the more or less uniform dates of Christmas vacations of the various medical schools. The next or second annual meeting of the Student A.M.A. will be held in December, 1951, but exact dates have not yet been announced.

KANSAS CITY SOUTHWEST CLINICAL SOCIETY

Last year the Kansas City Southwest Clinical Society established a fund for a Merit Award for graduates in medicine serving residences or internships in approved hospitals in this area. Each year the contest is limited to residents and/or interns on duty in a hospital of Arkansas, Colorado, Iowa, Kansas, Missouri, Nebraska, or Oklahoma. Awards will be given for the three best papers submitted. Each paper must represent original work by the essayist. This work may be a review of clinical cases in the hospital or actual experimental work in the laboratory in which the contestant is serving a residency or internship.

The winner of the first award will receive $500.00 and will be a guest speaker before the General Assembly of Physicians at the Annual Fall Clinical Conference of this society, presenting his winning thesis. The winners of the second and third awards will receive $100.00 and $50.00, respectively. This society was well pleased with the response last year; however, the fact has been brought to our attention that some residents and interns had not been notified about this award. This year we are asking you, the chairmen of Resident-Intern Committees, to please pass the above information on to each resident and/or intern in the hospital and to lend whatever encouragement you can to their participation in this contest.

In order to participate in this contest, applications must be made in writing with the endorsement of the chairman of the Resident-Intern Committee or the superintendent of the hospital and mailed to the executive office of the society by April 15, 1951. Papers will be accepted for this contest up to and including August 1, 1951.

JAMES R. McVAY, M.D.
630 Skukert Building,
Kansas City, Mo.

The International Post-Graduate Medical Assembly of Southwest Texas will hold its annual meeting in San Antonio, Texas, at the Municipal Auditorium, January 22, 23, 24, 1952, Dr. Thomas H. Sharp, President; Dr. John J. Hinchey, Treasurer.

AMERICAN COLLEGE OF CHEST PHYSICIANS

The Seventeenth Annual Meeting of the American College of Chest Physicians will be held at the Ambassador Hotel, Atlantic City, New Jersey, June 7 through 10, 1951. An interesting scientific program has been arranged for presentation at the meeting.

The Board of Examiners of the college has announced that the next oral and written examinations for Fellowship will be held in Atlantic City on June 7. Candidates who would like to take the examinations for Fellowship should contact the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

The Convocation ceremonies will be held at the Ambassador Hotel, Atlantic City, on Saturday, June 9, at which time certificates will be awarded to new Fellows of the College.

Tuberculosis Abstracts

Issued Monthly by the National Tuberculosis Association

Vol. XXIV APRIL, 1951 No. 4

DROP IN TUBERCULOSIS DEATHS AMONG YOUNG PEOPLE CALLS FOR INCREASED EMPHASIS ON OLDER AGE GROUPS

Mary Dempsey, Statistician, National Tuberculosis Association, The NTA Bulletin, October, 1950.

The control of a disease like the waging of a war depends for success upon knowledge of the enemy, where he is to be found and in what numbers. This knowledge about tuberculosis is to be found in an analysis of the death rates from the disease. Tuberculosis control programs which ignore the implications of the changing character of tuberculosis mortality are missing the golden opportunity now at hand to eradicate the disease.

During 1948, the actual number of deaths from tuberculosis in the United States was 43,833, a decrease of 8.8 per cent when compared with 1947. These final figures compiled by the National Office of Vital Statistics in Washington are published in Public Health Reports for April 7, 1950.

When age groups are considered, however, the decline in the number of deaths is extremely uneven. For example, tuberculosis deaths among young persons 15 to 24 dropped 26.2 per cent between 1947 and 1948, while among elderly persons 65 years of age and over there was an actual increase of 0.5 per cent (one-half of one per cent).

During the past decade the decline in the number of tuberculosis deaths among those 15 to 24 was by no means comparable with the drop between 1947 and 1948. The almost steady increase in the percentage of decline in the deaths among those in this age group appears in the following table.

TABLE 1

Percentage decline from one year to the next in the number of tuberculosis deaths among persons 15 to 24 years of age: United States, 1939-1948

Years	Percentage decline in the number of tuberculosis deaths among persons 15 to 24 years of age
1947-1948	26.2
1946-1947	12.1
1945-1946	10.4
1944-1945	7.7
1943-1944	7.7
1942-1943	4.5
1941-1942	5.6
1940-1941	3.5
1939-1940	2.8

The probable explanation of this extraordinary drop in the 15 to 24 year age group is that in this country young people of today are exposed to much less tuberculous infection than was the case a few decades ago. It is likewise probable that most people have increased resistance. A third theory might be that those in the younger adult groups have become somewhat health conscious as the result of long-continued health education programs. Yet it is difficult to account for such a pronounced difference in very recent years. During the five-year period, from 1937 to 1942, tuberculosis deaths in this one age group (15 to 24 years) dropped 24.9 per cent, less than the percentage decline in one year between 1947 and 1948.

Analysis of the number of tuberculosis deaths in each age group between 1947 and 1948 presents more complete information on this subject.

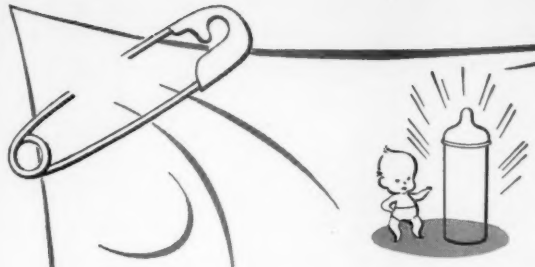

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TABLE 2

Percentage increase or decrease in actual number of tuberculosis deaths, classified by age group: United States, 1947 and 1948

Age group	Deaths from tuberculosis 1948	1947	Percentage increase or decrease 1947-1948
All ages	43,833	48,064	— 8.8
Under 15 years	1,636	1,698	— 3.7
15-24 years	3,933	5,332	—26.2
25-34 years	6,591	7,697	—14.4
35-44 years	7,573	8,314	— 8.9
45-54 years	8,165	8,865	— 7.9
55-64 years	7,737	7,999	— 3.3
65 years and over	8,168	8,130	+ 0.5
Age unknown	30	29	+ 3.4

Surprisingly enough, deaths among children under 15 years of age dropped very little, though the numbers involved are small. Beginning with the group 15 to 24 years old, the decline is very pronounced and becomes less so with each succeeding age group. Few compilations point out so strongly the increasing concentration of tuberculosis deaths among older people.

Another comparison of interest has to do with the decline in the actual number of deaths according to sex. In spite of the fact that deaths among males are nearly twice as numerous as among females, deaths among the former are nevertheless declining at a much slower rate. This statement is true whether one considers white people only or non-whites (See Table 3).

TABLE 3

Percentage decrease in actual number of tuberculosis deaths, classified by sex and color: United States, 1947 and 1948

Sex and color	Deaths from tuberculosis 1948	1947	Percentage decrease 1947-1948
Total	43,833	48,064	8.8
Male	28,552	30,585	6.6
Female	15,281	17,479	12.6
White	31,750	34,783	8.7
Male	21,616	23,167	6.7
Female	10,134	11,616	12.8
Non-White	12,083	13,281	9.0
Male	6,936	7,418	6.5
Female	5,147	5,863	12.2

These findings conform to the long-held impression that tuberculosis becomes increasingly a disease of men and particularly of older men.

Careful study of these mortality data points first to outstanding achievements of the many agencies (both official and voluntary) which have for so long waged war against tuberculosis, and second to those areas of activity in which success has been much less marked. It is evident that more concentrated efforts must be directed toward control and ultimate eradication of the disease among men, among older people, and among non-white people if the total program is to continue to be as successful as it has been in the past.

TABLE 4

Percentage decrease in actual number of tuberculosis deaths, classified by form of disease: United States, 1947 and 1948

Form of disease	Deaths from tuberculosis 1948	1947	Percentage decrease 1947-1948
All forms	43,533	48,064	8.8
Pulmonary	40,420	44,462	9.1
Other forms	3,413	3,602	5.2

Inasmuch as the actual number of deaths is used in each instance—and not death rates—it is obvious that the great increase in the country's population has not been taken into consideration. Inclusion of this factor would serve to accentuate rather than to minimize the declines noted.

The Book Corner

New Books Received

Community Health Educator's Compendium of Knowledge: By Clair E. Turner, A.M., Ed.M., D.Sc., Dr.P.H. Professor of Public Health Emeritus, Massachusetts Institute of Technology; Assistant to the President, National Foundation for Infantile Paralysis; Consultant in Health Education, World Health Organization; formerly Associate Professor of Hygiene, Tufts Medical and Dental Schools; formerly Chief Health Education Officer, Institute of Inter-American Affairs; formerly visiting Professor of Health Education School of Public Health, University of California. St. Louis. The C. V. Mosby Co., 1951. Price, $3.00.

The Microkaryocytes, the Fourth Corpuscles and Their Functions: By K. G. Khorozian, A.B., M.S., M.D., Pineville, West Virginia. Boston Meador Publishing Co. Price, $12.00.

The Eye Manifestations of Internal Diseases (Medical Ophthalmology): By I. S. Tassman, M.D. Associate Professor of Ophthalmology, Graduate School of Medicine, University of Pennsylvania, Philadelphia; Attending Surgeon, Wills Eye Hospital, Philadelphia, Pennsylvania. With 279 illustrations including 25 in color. Third edition. St. Louis, The C. V. Mosby Co., 1951. Price, $12.00.

Book Reviews

Principles of Public Health Administration: By John J. Hanlon, M.S., M.D., M.P.H., Associate Professor of Public Health Practice, School of Public Health, University of Michigan, and Chief Medical Officer and Associate Chief of Party, Bolivia, The Institute of Inter-American Affairs. With 48 illustrations. St. Louis, The C. V. Mosby Company, 1950. Price, $6.00.

This is a basic and very readable text for not only professional public health workers, but those in the medical sciences who wish to understand the modern role of public health. The book stresses the need for doctors, nurses, sanitarians and educators to have the special training to apply medical and scientific facts to the problems of community health.

The chapters on philosophy, background, and the socio-economic justifications of public health comprise the first eight pages, and the organization, financing, legality, and public relations of public health activities are discussed in the next 190 pages. The last half of the book is a helpful summary of the present patterns of public health services in the U. S. pertaining to vital statistics, laboratories, communicable disease control, maternal and child health, chronic dis-

eases and adult health, and public health nursing. The final chapters deal with the relationships of public health with private physicians, medical care, and private enterprise.

The book is worthy of brief perusal or thoughtful study of all in the medical sciences.

MILDRED DOSTER, M.D.

The Mask of Sanity: An Attempt to Clarify Some Issues About the So-Called Psychopathic Personality. Non teneas aurum totum quod splendet ut aurum. Alanus de Insulis: By Hervey Cleckley, M.D., Professor of Psychiatry and Neurology, University of Georgia School of Medicine, Augusta, Georgia. Second edition. St. Louis, The C. V. Mosby Company, 1950. Price, $6.50.

To anyone interested in the problems of the psychopathic personality, this book is an excellent, although rather verbose, descriptive text.

The present edition contains half again as many pages as the first edition (1941). This increase in volume is due to the elaboration of and addition to previous material with little change in actual content.

The author, by the use of bountiful case material and comparison with other psychopathological entities, leaves little doubt as to what the "psychopath" is, as well as what he isn't.

In regard to etiology, most of the present concepts are touched upon, as well as an elaboration of the author's concept of this condition as a "semantic disorder." This latter has to do with ". . . a specific failure of ordinary affective responses to arise and find their way normally into integrated reactions of the organisms," i.e., in more simple language, the psychopath is lacking in the feeling of "rewards of love, the hard job well done, of faith kept despite sacrifices, etc."

The author lays no claim to an effective treatment procedure. He makes a strong plea, however, for reaching medico-legal agreement with regard to the incompetency of the psychopathic personality in order that authority may be given our present hospitals to hold and deal sensibly with patients of this sort. Example: Greenstein Act, Pennsylvania.

Support is given to prefrontal lobotomy or similar operations for psychopaths "severely disabled and unresponsive to other therapy." The author in closing points out that the cost of even the most elaborate institutional treatment facilities for these people would not equal the financial loss they now inflict, apart from their socially damaging effect.

WRAY R. GARDNER, M.D.

Electrocardiography, Fundamentals and Clinical Application: By Louis Wolff, M.D., Visiting Physician, Consultant in Cardiology and Chief of the Electrocardiographic Laboratory, Beth Israel Hospital; Associate in Medicine, Harvard Medical School. Illustrated. Philadelphia and London. W. B. Saunders Company, 1950. Price, $4.50.

This 182-page volume by Dr. Wolff is divided into two parts. The first part deals with the electrophysical principles responsible for the formation of the electrocardiogram. He has sensed a need for such a book in order to remove electrocardiographic interpretation from a sort of an empirical practice based on the memorization of certain patterns known to be connected with certain cardiac abnormalities. In place of such a practice he has shown why one has the characteristic changes of myocardia infarction, bundle branch block, pericarditis, etc. The explanations are accompanied by a number of diagrams which are worth while.

The second part deals with clinical electrocardiography. This, in effect, is putting into practice the basic facts that have been presented

in the first part of the book. There are good chapters with numerous tracings as illustrations under such headings as the electrocardiogram, coronary heart disease, myocardial infarction, bundle branch block and ventricular hypertrophy. In some of the chapters there are case histories and accompanying diagrams which serve to fix the material in one's mind better.

The book is well written and is based on proven electrocardiograpic data. It is well indexed. There are no bibliographies at the ends of the chapters and he has not included anything on the cardia arrhythmias. Both of these, in my opinion, should be included in a book of this nature. There are very few books on the subject that attempt to explain electrocardiographic findings by using electrophysical principles. This is one of them and I believe Dr. Wolff has done a good job. For anyone interested in electrocardiography this book is worth having. I think that it is especially suitable for students, interns and residents.

WILLIAM E. HAY, M.D.

The Causation and Treatment of Delayed Union in Fractures of the Long Bone. (This Jacksonian Prize Essay is published with the kind permission of the Council of the Royal College of Surgeons of England): By Kenneth W. Starr, O.B.E., E.D., M.D., B.S. (Syd.), M.S. (Melb.), F.R.C.S. (Eng.), F.A.C.S., F.R.A.C.S., Surgeon, Sydney Hospital, New South Wales; Visiting Surgeon, Concord Military Hospital; Consulting Plastic Surgeon, Faculty of Dentistry, University of Sydney; Member of the Court of Examiners, Royal Australasian College of Surgeons; Lt.-Col. (R. of O.), A.A.M.S., late Officer Commanding Surgical Division. Butterworth & Co. (Publishers), Ltd., London, England. The C. V. Mosby Company, St. Louis, Mo., U.S.A., 1947. Price, $9.00.

This essay, finished in 1946, contains a great deal more information than the title might suggest. It is divided into three parts. Part I, entitled "The Morphogenesis of Bone," consists of one of the most lucid accounts of normal bone histology and of the chemistry of bone that the reviewer has read. Numerous references are made to the old German literature where a great number of fundamental advances to bone histology were made. All ideas, however, on this subject are brought up to date. Part II is devoted to "The Healing of Fractures." All the tissues involved in normal and infected bone repair are dealt with in detail, both from a histologic and chemical standpoint. The radiographic changes in fracture healing are portrayed. Part III contains a discussion of "The Aetiology and Treatment of Delayed Union." In this division, an attempt is made to correlate clinical principles of treating delayed union of fractures with the fundamental histologic and chemical data of the preceding parts. This part includes sections on etiologoy, statistics, adjuvant therapeutic methods, the clinical approach, the treatment of closed fractures, the management of open fractures, septic fractures, and the skin problem.

While this book contains little new or original information, nevertheless one may find everything known today concerning this involved and difficult subject between the covers. The subject matter is well-written and illustrated. Any criticism of the text, especially the treatment of fractures by antibiotics which has been advanced since the publication of this essay, would be relatively minor and would not detract from the intrinsic value of the book.

This essay should be studied by everyone interested in the healing of fractures.

BERNARD C. SHERBOK, M.D.

A Century of Medicine in Jacksonville and Duval County. By Webster Merritt, M.D. Price, $3.50. Pp. 220. Illustrations 44. Gainesville, Fla.: University of Florida Press, 1949.

Physicians and laity alike will find in this engaging narrative a most important contribution to Florida's medical and historical lore. With the sure and forthright touch of the true historian, Dr. Merritt presents in panoramic review the fascinating events, towering personalities and progressive movements of the entire nineteenth century as they pertain to medicine in Jacksonville and Duval County. His exhaustive research and painstaking efforts have brought to light in highly readable form history long obscured, owing to loss of official records in the Jacksonville fire of 1901. In sifting out the facts for this entertaining and accurate account, he pictures the physician as community builder and harbinger of progress as well as practitioner of medicine, and his facile pen loses none of the drama of the terrifying yellow fever and other epidemics or the gala events of the times. With equal skill he traces the foundation and early history of the Florida Medical Association and of the Florida State Board of Health. The author is a brilliant scholar and able historian who has made notable contributions to Florida history in The Journal and able historian who has made notable contributions to Florida history in The Journal and in historical publications. His book is profusely illustrated throughout its twenty chapters and makes a valuable addition to any library, particularly that of the physician.

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GENERAL PRACTITIONER: Age 26, Married, German, Congregationalist. Graduate University of Illinois. One year internship, one year surgery residency, one year medical residency. Desires general independent practice town of 5,000 to 20,000. Draft exempt. Available July 1. For further information, please write Ann Woodward, Woodward Medical Personnel Bureau, 185 North Wabash, Chicago, Illinois.

DESIRE LOCUM TENENS in Utah of 2 to 6 weeks' duration, months of July and August, 1951. 30 years of age, white, male, married. Graduated University of Medical School, 1950. Write W. Petty, M.D., Wayne County General Hospital, Eloise, Michigan.

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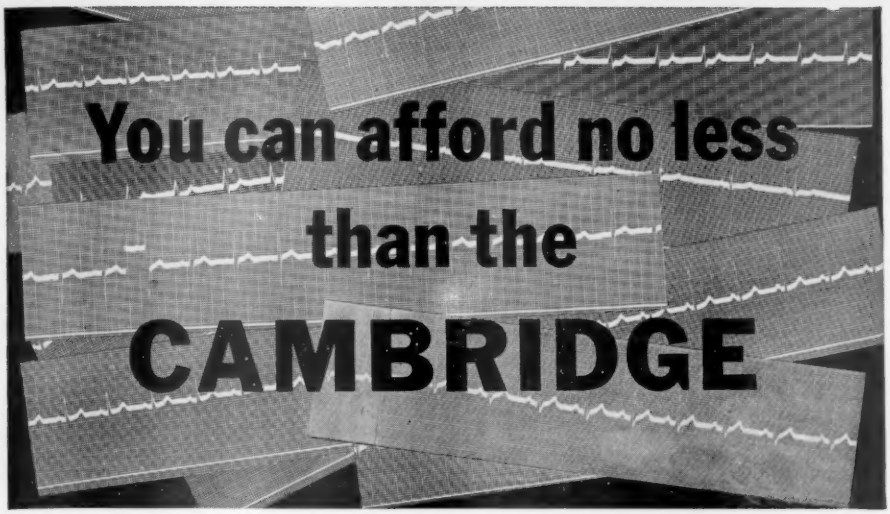

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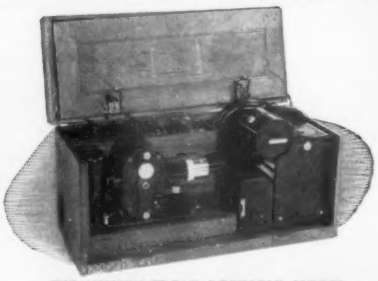

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1. Thewlis, M., and Gale, E. T.: Ambulatory Care of the Aged, Geriatrics, 5:331 (Nov.-Dec.) 1950.

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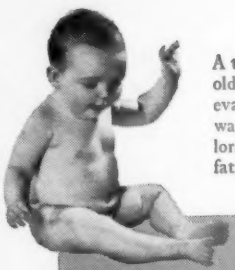

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